Maryland Department of Health & Mental Hygiene

AIDS Administration

Ryan White Part B
2009-2011 Comprehensive Plan

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Introduction and Overview

There are over 34,000 people living with HIV/AIDS in the state of Maryland. There is a comprehensive system of care within the state that addresses the needs of people living with HIV/AIDS. The federal government, through the Ryan White HIV/AIDS Treatment Modernization Act of 2006 ("Ryan White Act" hereafter), provides formula grant funding to the state to ensure access to this comprehensive system of HIV care and medications for those who are uninsured and cannot afford to pay for care. The Ryan White Act directs the Health Resources Services Administration (HRSA) to distribute funding based on the number of people living with HIV/AIDS and provides resources to address the needs of special populations and geographic challenges. The AIDS Administration of the Maryland Department of Health and Mental Hygiene receives dollars from HRSA to cover statewide services (through Part B of the Ryan White Act) and for programs targeting women, infants, children and youth (through Part D of the Ryan White Act). The AIDS Administration partners with the other jurisdictions and agencies that receive Ryan White funds for Marylanders with HIV to develop and ensure a comprehensive system of care.

The Ryan White Act requires Part B grantees to draft and implement statewide comprehensive plans, including a description of HIV-related services in the state, available resources, epidemiological data, service needs, goals and strategies. HRSA's guidelines relating to this legislative requirement indicate that the comprehensive plan should serve as a guide for the design and implementation of a continuum of HIV care over a three-year period. The guidelines state further that the plan should address disparities in HIV care, access and services among affected subpopulations and historically underserved communities, and the needs of those who know their HIV status and are not in care, as well as the needs of those who are currently in the care system.

As stated in its mission statement, the AIDS Administration of the Maryland Department of Health and Mental Hygiene (DHMH), established in 1987, "is dedicated to working with public and private partners to reduce the transmission of HIV and help Marylanders with HIV/AIDS live longer and healthier lives. This is accomplished by promoting and developing comprehensive, compassionate and quality services, for both prevention and care. The AIDS Administration provides leadership, encourages input from affected communities, and uses scientific knowledge to guide the development of responsible and effective policies and programs."

In line with this mission, the Maryland HIV Services Comprehensive 2009-2011 Plan includes broad goals, principles and strategies for engaging and retaining all HIV infected persons in high quality care and services early in their diagnosis and throughout their diagnosis. This plan is designed to guide implementation of Ryan White Parts B and D and state-funded HIV/AIDS services in Maryland. The plan is organized into four sections that address the HRSA-required key planning questions: "Where are we now?" "Where do we need to go?" "How will we get there?" and "How we will monitor our progress?"

The first section of the plan addresses the question of "where are we now?" and describes the HIV/AIDS epidemic in Maryland and examines the resources available for HIV services. This

section also discusses specific needs for core HIV medical services and describes the state's estimates of unmet need for HIV primary medical care, including the methodology utilized for this calculation. Gaps in services and barriers to care are also briefly described. A more complete description of the needs for HIV services in Maryland is contained in the 2009 Statewide Coordinated Statement of Need.

The second section of the plan addresses the question "where do we need to go?" and describes the vision and values that guide the AIDS Administration's goals and principles for the provision of HIV services to advance the mission of the Part B and Part D programs.

The third section of the Comprehensive Plan addresses the question "how will we get there?" and lists the six long-term goals that guide the AIDS Administration HIV Service programs in order to meet our shared vision. Section three also contains the implementation plans for meeting the long-term and short-term (annual) goals. The long-term goals are:

1. Coordinate a collaborative system of HIV care across all Ryan White Parts and with other service providers.

2. Ensure people who are newly diagnosed HIV-positive and those not in care enter care by collaborating with Counseling, Testing and Referral (CTR) programs and facilitating connections to care and support services.

3. Improve health outcomes by ensuring access to comprehensive, high quality, culturally competent health care for all persons living with HIV/AIDS, emphasizing the importance of retention in care, treatment adherence support and prevention with HIV-positive individuals.

4. Ensure timely and on-going access to life-saving medications for all uninsured and underinsured persons living with HIV/AIDS in Maryland.

5. Improve access to mental health services and substance/alcohol abuse counseling and treatment for persons living with HIV/AIDS and co-morbidities.

6. Provide appropriate case management and access to essential supportive services that enable persons living with HIV/AIDS to seek treatment, remain in care and adhere to medication regimens. Such services include but are not limited to: non-medical case management, medical nutritional counseling, housing assistance, transportation, and emergency financial assistance.

The final section addresses the question "how will we monitor our progress?" and describes the monitoring and evaluation processes in place for measuring progress towards performance goals, quality of care provided and client-level outcomes.

I. Where We Are Now: Our Current System of Care

In this section, the HIV/AIDS epidemic in Maryland is described. This section also describes the state's estimate of unmet need for HIV primary medical care and the methodology utilized for this calculation. Gaps in services and barriers to care are also briefly described. A full description of the needs for HIV services in Maryland is contained in the 2009 Statewide Coordinated Statement of Need.

The HIV/AIDS Epidemiological Profile for Maryland

The state of Maryland has been significantly impacted by the HIV epidemic. Maryland had the third highest AIDS case report rate (29.0 cases per 100,000 population) among states and territories and the Baltimore-Towson metropolitan area had the second highest AIDS case report case rate among major metropolitan areas (37.7 cases per 100,000 persons) in 2006. This section will describe how data is collected and what the data tells us about the impact of HIV/AIDS on specific populations and regions of the state.

How Data is Collected and Reported

The Maryland HIV/AIDS Reporting Act of 2007 became law on April 24, 2007. The law expanded HIV and AIDS reporting, instituted reporting for HIV-exposed newborns, changed Maryland's HIV reporting from a code-based to a name-based system as is done with AIDS cases, increased the restrictions on the use of surveillance data, and increased the penalties for misuse of surveillance data. The state has just completed a major effort to transition from code-based to name-based HIV surveillance; hence, the data collected under the new system were not yet available for this report.

This report uses the HIV and AIDS surveillance data available in 2008 that was used during the statewide planning process and for the FY2009 Ryan White funding application. HIV data are available only for those tested since 1994, when HIV surveillance began. HIV and AIDS incident cases are not necessarily mutually exclusive since HIV cases may have progressed to AIDS during the presented time period and therefore count as both a new case of HIV and a new case of AIDS. HIV and AIDS prevalent cases are mutually exclusive categories; therefore, HIV prevalent cases are only those cases that have not developed AIDS. Due to the delay in case reporting, the data are presented with a one year lag, at which point it is estimated that over 90% of cases will have been reported.

Notes on Data Collection and Interpretation

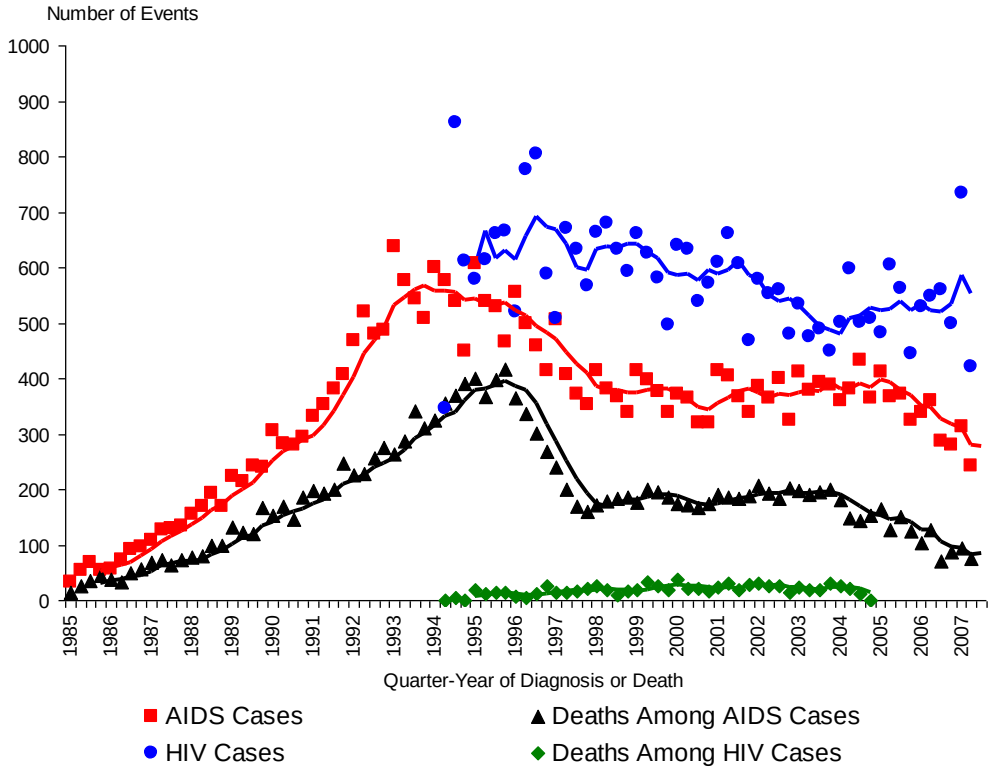
The HIV prevalence estimates for race/ethnicity, gender, age, and mode of exposure include HIV cases diagnosed since June 1, 1994 that have not died or progressed to AIDS as reported through June 30, 2007, as reported through June 30, 2008. These figures are likely to be an undercount of prevalent HIV infections for three reasons. First, tests performed on Maryland residents at facilities outside of Maryland are not reported. Second, individuals that tested positive prior to 1994 and have not been re-tested will not be included until they are either re-tested or develop AIDS. Third, the CDC estimates that, as many as 21% of HIV infected individuals do not know their HIV status.

Maryland's HIV/AIDS Epidemic Compared to the National Epidemic

Approximately 5.3 million people reside in Maryland which ranks 19th among all states relative to population size; however the state was 9th in cumulative number of AIDS cases (30,571 through 2006). Maryland had the third highest AIDS case report rate (29.0 cases per 100,000 population) among states and territories and the Baltimore-Towson metropolitan area had the second highest AIDS case report case rate among major metropolitan areas (37.7 cases per 100,000 persons) in 2006. This is in comparison to the national AIDS case rate of 12.9 cases per 100,000 persons. Maryland's case rate is 2.24 times higher than the national rate. The Baltimore-Towson EMA's, AIDS case rate is 2.9 times higher than the national rate.

The number of incident (new) AIDS cases diagnosed in each quarter increased through 1995, with an artificial rise around 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there has been a substantial decline in both the number of new cases of AIDS (to 243 in the second quarter of 2007) and in deaths among AIDS cases (to 76 in the second quarter of 2007). The number of deaths among AIDS cases declined at a faster rate than the number of new AIDS cases per year, resulting in an increase in the number of people living with AIDS each year (prevalence). The number of new HIV cases reported each quarter has declined slightly since surveillance began in 1994 (2% per year to 554 in the second quarter of 2007). However, the total number of living HIV cases (reported since 1994) and AIDS cases has been steadily increasing. The number of deaths among HIV cases has remained low and stable since 1994, with a more pronounced decrease in AIDS and HIV deaths since 2004.

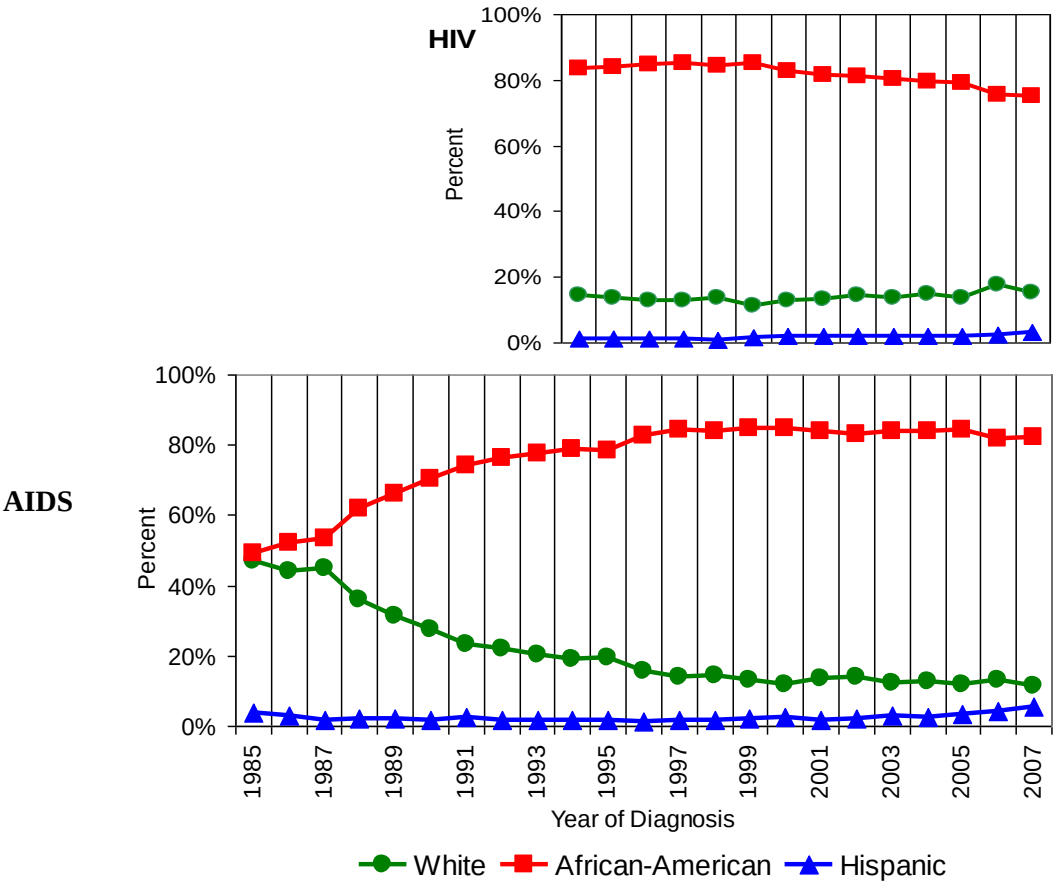
Figure 1. HIV and AIDS Case Trends: Incident (Newly Diagnosed) HIV and AIDS Cases and Deaths among HIV and AIDS Cases by Quarter-Year through Second Quarter 2007 as Reported through 6/30/08
Source: Maryland HIV/AIDS Epidemiological Profile – June 30, 2008.



HIV/AIDS Data by Region, Race/Ethnicity and Exposure Category

There were a total of 34,024 living HIV and AIDS cases in the State of Maryland as of June 30, 2007, of which 19,042 (56%) were HIV cases and 14,982 (44%) were AIDS cases. About half (48%) of all reported living HIV and AIDS cases in Maryland were residents of Baltimore City at time of diagnosis. The Central Region, which includes Baltimore City and the surrounding counties, Anne Arundel, Baltimore, Carroll, Harford, and Howard, reported a total of 62% of all living cases. The two counties adjacent to Washington, D.C., Montgomery and Prince George's counties (with 9% and 16% of cases, respectively) make up the Suburban Region with 24% of living cases. A large percentage of HIV and AIDS cases are diagnosed within the state correctional system (8% of living HIV/AIDS cases). The Eastern Region (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties) reported 3% of all living cases. The Western Region (Allegany, Frederick, Garrett, and Washington counties) reported 2% of all living HIV and AIDS cases, and the Southern Region (Calvert, Charles, and Saint Mary's counties) reported 1% of all living HIV and AIDS cases.

Figure 2. HIV and AIDS Case Race/Ethnicity Trends: Proportions by Race/Ethnicity of Incident (Newly Diagnosed) Cases during each Calendar Year Reported through 6/30/08



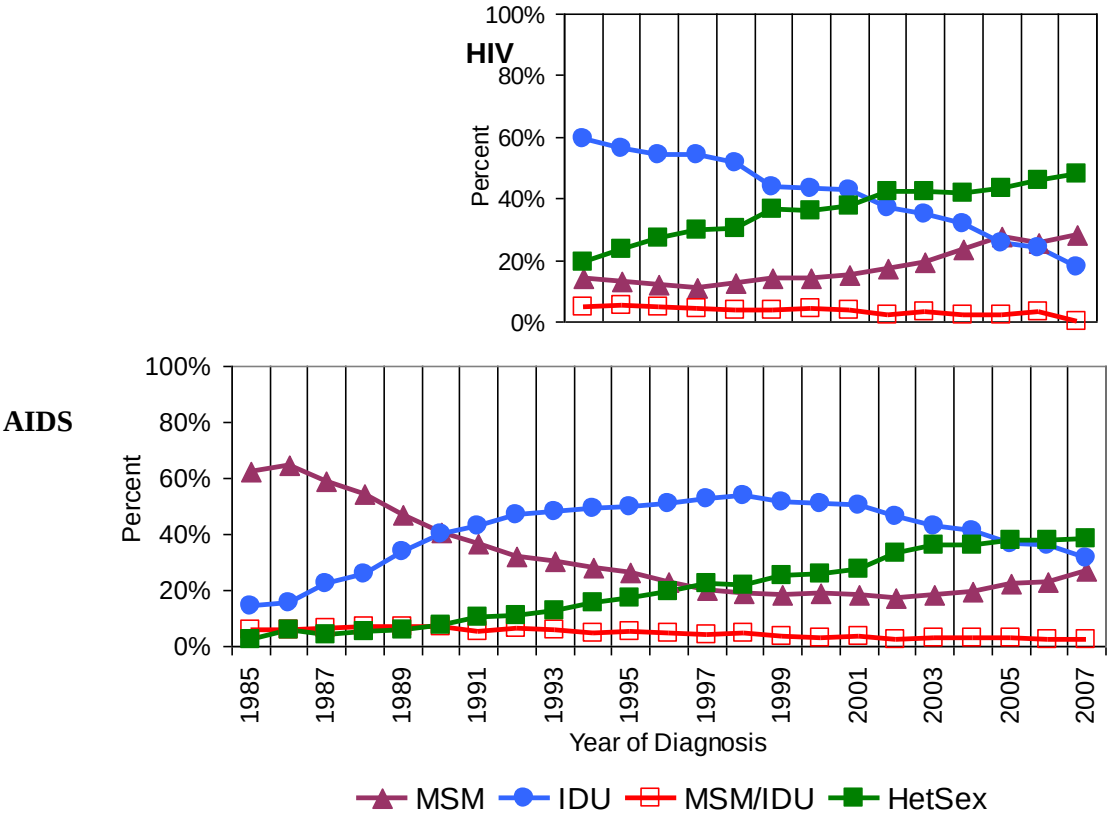
Source: Maryland HIV/AIDS Epidemiological Profile – June 30, 2008.

Maryland living HIV and AIDS cases are predominantly African-American (81%), male (64%), and middle-aged (60% of cases are 30-49 years old). The largest single demographic group is African-American males, aged 40-49, with 21% of all HIV and AIDS cases. The percentage of

female cases has been increasing over time. Of all AIDS cases diagnosed in 1985, 10% were female. This proportion has steadily increased to 39% of AIDS cases in 2007. Thirty-eight percent of all HIV cases in 2007 were female. The percentage of African-American cases has been increasing over time. Of all AIDS cases diagnosed in 1985, 49% were African-American. This proportion has steadily increased to 82% in 2007. Seventy-five percent of all HIV cases in 2007 were African-American.

Men who have sex with men (MSM) was the most common HIV transmission risk group for AIDS cases until 1990. In 1991, injection drug use (IDU) became the most commonly reported exposure among newly diagnosed AIDS cases. Heterosexual contact (HetSex) has represented an increasing proportion of reported exposure among all new AIDS cases, surpassing MSM in 1997 and IDU in 2006. Injection drug use was the predominant mode of HIV transmission for HIV cases. However, by 2002 a greater proportion of newly reported HIV cases have identified transmission risk as heterosexual contact, and since 2005, there have been more MSM cases than IDU cases.

Figure 3. HIV and AIDS Case Exposure Category Trends: Proportions by Exposure Category of Incident (Newly Diagnosed) Cases during each Calendar Year Reported through 6/30/08



Source: Maryland HIV/AIDS Epidemiological Profile – June 30, 2008.

Presented in Table 1 below are Maryland's reported two-year AIDS incidence (January 1, 2006 through December 31, 2007), AIDS prevalence on June 30, 2007, and HIV non-AIDS prevalence on June 30, 2007 using data reported through June 30, 2008. The HIV/AIDS data generated by the State of Maryland are used rather than that provided by the CDC because 1) the State's data are used in all phases of assessing need, planning for services, and allocating resources, 2) the State's AIDS data are more current than the CDC data, and 3) the State's HIV data represent actual case counts whereas the CDC HIV data are based on statistical estimates using data from other states.

Table 1: AIDS Incidence, AIDS Prevalence and HIV Prevalence by Demographic Group and Exposure Category

	AIDS Incidence 1/1/06-12/31/07		**AIDS Prevalence 6/30/07**		**HIV (non-AIDS) Prevalence 6/30/07**	
	N	**%**	**N**	**%**	**N**	**%**
Total	2,262	100.0	14,981	100.0	19,042	100.0
Age*	**N**	**%**	**N**	**%**	**N**	**%**
<13	1	0.0	38	0.3	171	0.9
13-19	40	1.8	145	1.0	157	0.8
20-44	1,329	58.8	6,733	44.9	9,929	52.1
45+	892	39.4	8,065	53.8	8,785	46.1
Race/Ethnicity	**N**	**%**	**N**	**%**	**N**	**%**
White, non-Hispanic	282	12.5	2,356	15.7	2,173	14.0
Black, non-Hispanic	1,856	82.1	12,084	80.7	12,604	81.4
Hispanic	108	4.8	463	3.1	278	1.8
Asian/Pacific Islander	15	0.7	65	0.4	53	0.3
American Indian	1	0.0	13	0.1	32	0.2
Multi-race/Other	0	0.0	0	0.0	339	2.2
Not Specified**	0	---	0	---	3,563	---
Gender	**N**	**%**	**N**	**%**	**N**	**%**
Male	1,407	62.2	9,936	66.3	11,873	62.5
Female	855	37.8	5,045	33.7	7,109	37.5
Not Specified**	0	---	0	---	60	---
Exposure Category	**N**	**%**	**N**	**%**	**N**	**%**
MSM/IDU	36	2.4	486	3.7	123	1.8
MSM	365	24.6	3,224	24.3	1,045	15.3
IDU	506	34.1	5,441	41.0	2,365	34.7
Heterosexual	560	37.8	3,832	28.9	3,022	44.3
Pediatric	10	0.7	197	1.5	231	3.4
Other	5	0.3	76	0.6	37	0.5
Not Specified**	780	---	1,725	---	12,219	---

* Incidence, age at diagnosis. Prevalence, age on 6/30/2007.

** Not Specified was not used in calculating percent distributions.

Source: Maryland Department of Health and Mental Hygiene, AIDS Administration, Center for Surveillance and Epidemiology, December 24, 2008.

Epidemiological Trends

The number of new AIDS cases diagnosed and reported each year (incidence) has remained stable at around 1,550 per year since 1998. However, as people living with HIV/AIDS live longer, the number of living AIDS cases (prevalence) has been increasing by about 800 cases per year during this same time, an average 10% per year increase in AIDS prevalence. Living cases of HIV has also been increasing since 1998, by almost 1,100 cases per year, an average increase of 12% per year. The demographics of prevalent HIV and AIDS cases have not changed substantially in the past two years. However, consistent with longer-term trends, the distribution of cases by exposure category has been slowly changing with fewer injection drug user cases and more heterosexual contact and MSM cases. At the end of 2000, the HIV/AIDS prevalent cases were 19% MSM, 48% IDU, and 26% heterosexuals, while by the middle of 2007 they were 21% MSM, 39% IDU, and 34% heterosexuals.

Unmet need estimate

Unmet need is defined as the proportion of persons known to have HIV/AIDS who are not receiving primary medical care. Primary medical care for HIV/AIDS is further defined as a patient having received either a CD4 count or a viral load test, or utilizing anti-retroviral medications during the prior year. Unmet need is calculated using a combination of laboratory reporting and antiretroviral medication use to identify persons in care and compares that to the number of people living with HIV/AIDS (prevalence) to determine the percentage of infected individuals receiving treatment and thus identifying the proportion of unmet need for HIV primary medical care.

Methodology

The AIDS Administration analyzed the laboratory reporting data and the antiretroviral medication use data to determine the number of unique persons having either a CD4 or viral load test during the past year or receiving antiretroviral medications. The number of persons receiving care was subtracted from the Maryland HIV/AIDS prevalence number for June 30, 2007 (the beginning of the one-year period) to develop an estimate of the number of persons not in care in Maryland. This number was then expressed as a percentage of persons not in care. Using the method and data described above we have calculated that 51% of the persons known to be living with HIV and AIDS in Maryland did not receive primary HIV medical services during the year ending June 30, 2008.

The denominator consisted only of persons diagnosed with HIV/AIDS, reported to the health department, and that were residents of Maryland at the time of diagnosis. The denominator may have also included persons whose death had not been reported. The numerator was a combination of persons with laboratory reports and medication usage. HIV viral load reporting was instituted recently and was possibly incomplete. While CD4<200 reporting was long-standing, CD4 reporting of 200 and above was instituted in 2007 and was likely incomplete. Laboratory reporting may also not include persons who receive care out of state. Medication usage consisted only of persons using the Maryland ADAP program, not all persons receiving antiretroviral medications.

Unmet Need Framework

Input	Value	Data Source
Population Sizes		
1. Number of Maryland resident cases living with HIV (PLWH) at the beginning of the comparison period	**19,042**	HIV case registry, prevalence on June 30, 2007, as reported through June 30, 2008
2. Number of Maryland resident cases living with AIDS (PLWA) at the beginning of the comparison period	**14,981**	AIDS case registry, prevalence on June 30, 2007, as reported through June 30, 2008
Care Patterns		
3. Number of unique persons in Maryland with CD4 or VL tests or receiving antiretroviral medications during comparison period	**16,599**	1) Laboratory reporting database, test results during July 1, 2007 through June 30, 2008, as reported through August 26, 2008. 2) ADAP database, program participants as June 30, 2008
Calculated Results		
4. Total number of Maryland resident cases living with HIV/AIDS (PLWHA) at the beginning of the comparison period	**34,023**	A+B
5. Number of Maryland PLWHA not receiving primary HIV medical care	**17,424**	D-C
6. Proportion of PLWHA in Maryland not receiving primary HIV medical care (quantified estimate of unmet need)	**51.2%**	(E/D)*100

As is demonstrated in the chart above, the AIDS Administration estimates that just over 50% of those who have tested positive with the HIV virus in Maryland are not currently receiving primary HIV medical care. A key part of any HIV/AIDS delivery system in Maryland must address engaging and sustaining people living with HIV/AIDS in primary HIV medical care.

The HIV/AIDS Delivery System in Maryland

Since the HIV virus was first detected in Maryland, the State, local governments and community-based organizations have worked together to develop a system and the delivery of HIV prevention and care services. The continuum of care for people living with HIV/AIDS in Maryland is comprised of a range of services and providers and represents a partnership of public and private agencies and funding. The continuum of care consists of HIV prevention and core and support HIV care services.

Prevention

The Maryland AIDS Administration receives funding from the Centers for Disease Control and Prevention for HIV prevention activities which include community planning, counseling and testing, health education and risk reduction programs, public information, capacity building/training, partners services, and monitoring and evaluation.

A major goal of HIV prevention is provide programs and policies that promote increased access to HIV counseling and testing for all individuals in Maryland. Early detection of HIV through routine HIV testing is directly linked with both positive health outcomes for HIV and with decreased costs to the health care system. As part of its HIV counseling and testing initiatives, the Maryland AIDS Administration also requires linkages to care for those who are newly diagnosed or those who know their HIV status but have not yet engaged with HIV care services. The AIDS Administration is working directly with clinical providers to incorporate both general HIV prevention messages into encounters with individuals already living with HIV. Current legislation requires health care providers to actively engage in or refer to Partner Services activities.

The Maryland Community Planning Group (CPG) also works with the AIDS Administration to review data and information to determine the priority populations for HIV Prevention initiatives. Currently, Maryland's HIV Prevention priority populations are:

1. Persons living with HIV/AIDS
2. Heterosexual
3. Men who have sex with men
4. Injection drug-users
5. Special populations (Latinos Deaf, Transgenders.)

(All behavioral groups emphasize African Americans due to disproportionate impact.). These priority populations reflect the Centers for Disease Control and Prevention requirements and the risks associated with new HIV infections in the state.

The State's Response

The Department of Health and Mental Hygiene has provided leadership at the state level through the support for legislation to appropriately address a range of issues related to HIV and through the development of programs to address those impacted by HIV who are the most vulnerable.

Maryland's Legislative Response

Maryland has enacted several pieces of legislation that addresses the needs of people living with HIV/AIDS and those who are at risk to acquire the disease. The statutory response has focused on three main areas: transmission prevention, treatment, and counseling, testing, and referral services.

Maryland HIV/AIDS Reporting Act. In response to the new requirements to qualify for federal funding under the Ryan White Act, Maryland enacted the Maryland HIV/AIDS Reporting Act of 2007. Of primary importance, the Act changes the state's HIV surveillance system from a code-based HIV reporting system to a name-based system. The Act requires physicians who care for patients who are HIV positive or AIDS-defined to report surveillance information to Maryland's Secretary of Health and Mental Hygiene and to local health officers. Additionally, the Act requires laboratories to report information on positive HIV test results to the Secretary. Further, the Act requires certain institutions to report information on patients in their care who are HIV positive or AIDS-defined to the Secretary and to local health officers.

HIV Testing- Informed Consent and Treatment Act. In April 2007, the Maryland General Assembly passed legislation (HB781/SB746) that required the AIDS Administration to form a

work group to review the CDC's "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Healthcare Settings", best practices, research and data on HIV counseling and consent processes. The workgroup was comprised of HIV-infected individuals, HIV/AIDS advocacy organizations, HIV service providers and other stakeholders. The process yielded a comprehensive set of recommendations on potential changes to current Maryland law for HIV counseling and testing processes, which was given to the Maryland General Assembly in December 2007. During the 2008 legislative session, the General Assembly passed House Bill 991/Senate Bill 826, entitled "HIV Testing-Informed Consent and Treatment Act", in an effort to increase access to HIV testing by removing reported barriers. This act alters the requirements for informed consent for HIV testing. Under the act, if testing is ordered at a health care facility, informed consent no longer needs to be documented on a separate, written form, but must be documented in the medical record. Testing performed at any other location requires a separate written informed consent form. The act also provides that an individual administering pretest counseling may utilize a wider array of communication methods based on the individuals' needs and testing history. Additionally, the act requires that an individual with a positive test result must be referred to treatment and supportive services. Further, the act requires health care providers of prenatal care to notify pregnant patients that they will be tested for HIV as part of routine, prenatal care, unless they decline such testing. Providers of labor and delivery services are required to consider offering rapid HIV testing to women with unknown HIV status, and to offer antiretroviral prophylaxis to those who test positive for HIV.

State Programs Outside the AIDS Administration

Within the Department of Health and Mental Hygiene there are other agencies that provide a range of health services to people living with HIV/AIDS (PWLHA). These agencies, which include the Alcohol and Drug Abuse, Family Health, Community Health and Mental Hygiene Administrations, collaborate with the AIDS Administration and with each other in providing integrated care for PLWHA. Because of the complexities of HIV treatment and care, many individuals must access several services to effectively meet their health and support needs. For example, in order to engage in and adhere to medication regimes for HIV treatment, an individual may first need access to mental health or substance abuse services to address issues that may impact their ability to comply with the complex antiretroviral medication regimes.

The AIDS Administration works with the Family Health Administration which overseas rural health and maternal/child health programs to assure access to primary care, prenatal and family planning services. The Maryland Medicaid Managed Care Program, called Health Choice, was implemented in 1997 and provides special capitation rates for HIV and AIDS to reimburse participating managed care organizations (MCOs) for the care of HIV clients. Other prescription and health insurance programs also administered by Maryland Medicaid include the Maryland Primary Adult Care (PAC) program and the Maryland Children's Health Insurance Program (MCHIP). PAC provides prescription coverage for low-income individuals who are not eligible for Medicaid. The comprehensive drug formulary includes coverage for medications for HIV/AIDS as well as other medical conditions. MCHIP provides health insurance coverage for middle to low-income children and pregnant women (who are at a maximum of 200% of poverty). Although MCHIP provides primary medical care, additional services that enable many

HIV-infected children to access and remain in care are not covered within this plan and therefore it falls to Part B and/or Part D funded programs to fill those gaps.

Ryan White-Funded Services

The Maryland AIDS Administration is the HRSA grantee for Ryan White Part B, Part B Minority AIDS Initiative Part D and Part D Youth Services Initiative grants. The AIDS Administration disburses, administers and monitors these Ryan White grants as well as Housing Opportunities for People with AIDS (HOPWA) funding from Housing and Urban Development and State General funds for HIV Care. The Ryan White Part B program consists of two parts: the Maryland AIDS Drug Assistance Program (MADAP) and the HIV Care program. MADAP provides access to 165 medications essential for the treatment of HIV/AIDS through a pharmacy assistance program and an insurance premium payment program. MADAP eligibility extends to 500% of the Federal Poverty Level. MADAP clients can access medications at 1,100 pharmacies across the state.

The AIDS Administration Ryan White Part B HIV Care funding can only be used for service categories as defined by HRSA. The Part B service categories are divided between two categories: core services (including outpatient/ambulatory health care, oral health care, mental health services, outpatient substance abuse services, medical case management, and medical nutrition therapy) and support services (including non-medical case management, emergency financial support (including Housing Assistance), psychosocial support services, medical transportation, and treatment adherence). HRSA's definitions for the service categories can be found in Appendix B.

The Ryan White Part B HIV Care dollars are allocated and disseminated to all 23 counties in the State and for Baltimore City via awards by the AIDS Administration to local health departments. The funding allocation is based on a formula that weighs HIV/AIDS prevalence, STD prevalence, poverty and a rural/urban variable. Each county health department determines which services will be provided for its clients based upon local needs as determined by the Regional Advisory Committee process (described later). The AIDS Administration requires that each jurisdiction ensure the availability of core HIV services to its residents. A list of Part B-funded service providers by service category can be found in Appendix C.

Part B funds for Baltimore City are competitively bid by service category via a Request for Proposals. The Part B funds are awarded to community-based organizations, hospitals and primary care clinics. Each local health department and Baltimore City sub-grantee have an assigned Health Services Administrator in the Center for HIV Care Services at the AIDS Administration who coordinates the monitoring, technical assistance, communication, data collection and other on-going needs with each provider.

Given the limitations of Ryan White funding, the AIDS Administration uses State General funds to fund HIV care clinics in two of the rural areas of the state where HIV specialty care is not otherwise available. The AIDS Administration contracts with two HIV care providers from Baltimore to travel to and provide these regional seropositive clinics.

In addition to the Part B and Part D services awarded by HRSA to the AIDS Administration, HRSA provides funding through Part A of the Ryan White Act to metropolitan areas impacted by the HIV epidemic. There are two Eligible Metropolitan Areas (EMAs) that include parts of Maryland that receive Part A funding: Baltimore-Towson and Washington, D.C. The AIDS Administration works closely and collaboratively with the Part A grantees to strengthen the continuum of care available to people living with HIV/AIDS in Maryland and to minimize duplication of services. For example, the AIDS Administration has two seats on the Greater Baltimore HIV Health Services Planning Council, representing the Part B and Part D programs, and will be joining the Washington Planning Council in 2009. Through the Planning Councils and the AIDS Administration's Regional Advisory Committees (described below), the AIDS Administration staff also communicate regularly with Ryan White Part C grantees and representatives from other federally and state-funded programs.

Assessment of Need

For the AIDS Administration, the Regional Advisory Committees (RAC) serve as the public advisory planning bodies that provide input and advice to the State of Maryland in the development and implementation of the State's HIV/AIDS comprehensive plan. The RAC provides an opportunity for community members interested in HIV/AIDS to network, discuss needs and develop a comprehensive continuum of care and prevention that effectively leverages funding from multiple streams and reduces duplication of resources. RACs are located in each of the five Maryland Regions (Central, Eastern, Southern, Suburban, Western) and meet four times a year. Each committee includes representatives from every major area of the AIDS Administration, HIV infected and/or affected community members, providers of services and/or prevention programs related to HIV, representatives from community, government and faith based organizations. All agencies across the State that receive Part B funding to serve individuals living with HIV have been required to participate as active members of the RAC in their region. These providers actively enlist the participation of community stakeholders and those infected and affected with HIV. Membership to the RAC is open—anyone who would like to attend is welcomed and is able to fully participate in the meetings.

A key role of the RACs is to provide information on the unique needs of each region in order to ensure that the needs of all populations are addressed in the Comprehensive Plan. This is done through meetings held throughout the year. The purpose of these meetings is to review the various services currently being provided in the region, review the allocation plan and provide feedback, consider epidemiological data, identify newly emerging underserved populations, review the various funding streams currently in place and prioritize service categories to fit the identified needs of the region. Specific examples of the role of the RACs in the needs assessment process include regional reports and discussions on emerging trends and populations at the RAC meetings and the Community Dialogue meetings held in each region to provide the community, especially consumers of services, the opportunity to discuss needs, service gaps and potential solutions.

The priorities that the Regional Advisory Committees set for 2009 are as follows:

Core Services	Support Services
Central Region	
1. Outpatient Ambulatory Health Services	1. Housing Services
2. Medical Case Management	2. Emergency Financial Assistance
3. Oral Health Care	3. Medical Transportation
4. Mental Health Services	4. Non-Medical Case Management
5. Substance Abuse Services-Outpatient	5. Psychosocial Support Services
6. Medical Nutrition Therapy	6. Outreach Services (tie)
	7. Food Bank/ Home Delivered Meals (tie)
	8. Childcare Services
Southern Region	
1. Medical Case Management	1. Housing Services
2. Outpatient Ambulatory Health Services	2. Emergency Financial Assistance
3. Oral Health Care	3. Medical Transportation
4. Mental Health Services	4. Non-Medical Case Management
5. Medical Nutrition Therapy	5. Food Bank/ Home Delivered Meals
6. Substance Abuse Services-Outpatient	6. Psychosocial Support Services
	7. Outreach Services
	8. Childcare Services
Suburban (DC) Region	
1. Outpatient Ambulatory Health Services	1. Emergency Financial Assistance
2. Medical Case Management	2. Non-Medical Case Management
3. Mental Health Services	3. Housing Services
4. Oral Health Care	4. Food Bank/ Home Delivered Meals
5. Substance Abuse Services-Outpatient	5. Psychosocial Support Services
6. Medical Nutrition Therapy	6. Medical Transportation
	7. Outreach Services
	8. Childcare Services
Western Region	
1. Medical Case Management	1. Non-Medical Case Management
2. Outpatient Ambulatory Health Services	2. Emergency Financial Assistance
3. Mental Health Services	3. Psychosocial Support Services
4. Oral Health Care	4. Housing Services
5. Substance Abuse Services-Outpatient	5. Medical Transportation
6. Medical Nutrition Therapy	6. Food Bank/ Home Delivered Meals
	7. Outreach Services
	8. Childcare Services
Eastern Shore	
1. Medical Case Management	1. Non-Medical Case Management
2. Oral Health Care	2. Medical Transportation
3. Mental Health Services	3. Emergency Financial Assistance
4. Substance Abuse Services-Outpatient	4. Psychosocial Support Services
5. Outpatient Ambulatory Health Services	5. Housing Services
6. Medical Nutrition Therapy	6. Food Bank/ Home Delivered Meals
	7. Outreach Services
	8. Childcare Services

While the Maryland Community Planning Group (CPG) for prevention services and the Regional Advisory Committees (RAC) have focused on efforts such as statewide and regional priorities and the overall consonance between resources and needs, more targeted planning groups have emerged to address narrower topics with more detail. Examples of these groups include: Baltimore City Commission on HIV/AIDS, Prince Georges County Syphilis Response Team, MSM Response Team, Transgender Response Team, NASTAD African American Women Forum. These have emerged in addition to the original planning groups such as the Washington DC and Baltimore EMA Part A Planning Councils.

The AIDS Administration also assesses need through specific questions on the statewide Client Satisfaction Survey that is administered each year. Over 1,900 consumers returned completed surveys this year. Consumers are asked about all unmet needs, the most important unmet need and why they feel their most important unmet needs are not being met.

Gaps and Barriers

Greater detail regarding the following needs and barriers for medical and supportive services is contained in the Maryland 2009 Statewide Coordinated Statement of Need.

Accessibility and availability of services

Improving access to quality health care is a critical step towards improving health outcomes for PLWHA in Maryland. The availability of services, and access to those available, was a common challenge listed in the SCSN meetings across the state. Clients, especially in the rural regions, highlight the need for trained infectious disease providers to provide their general care in a manner that is appropriate for their HIV/AIDS needs. Moreover, there is an increasing lack of specialty care providers, including care for co-morbidities, OB/GYN, emergency, and pediatric care. As identified in the 2001 and 2006 SCSNs, the need for increased days and hours and expansion of clinic locations and services is a need resulting from the rising number of PLWHA who live longer and are able to return to the workforce. While efforts have been made to increase service hours, days, and locations, access to care continues to be a concern.

Increased testing has led to an increased number of persons seeking services. Along with the increased number of people living with HIV, the work load for service providers has increased, resulting in burn out and provider turnover. New providers need to be given more in-depth HIV training on a routine basis. This training was cited in the earlier SCSN and was highlighted in all the 2008 RAC meetings. In a parallel manner, many RAC participants, especially in the rural regions, cited the lack of trained providers in their area, particularly primary care doctors and even infectious disease physicians knowledgeable about HIV, available services, and referrals.

Privacy and confidentiality training and sensitivity and cultural competency training have been identified as growing needs, especially in the rural areas of Maryland. The need for linguistic and cultural sensitivity, translators, and competencies was alerted to in both rural and urban regions. Latinos and African immigrant populations were specifically cited as requiring provider sensitivity in care.

Lack of client knowledge of available services
In the 2007 Baltimore EMA Consumer Survey, the most commonly cited barrier to care among EMA-wide consumers was insufficient knowledge of how to access services. "This barrier signifies either (1) communication problems between providers and consumers, either because the provider has not provided sufficient information or because the client has not been clear enough about his or her needs, or (2) client difficulty with correctly assimilating and retaining information about available services. As consumer needs evolve, there must be ongoing dialogue that supports (1) consumer's communicating their evolving needs and (2) providers' sharing information about available services efficiently and effectively.

Stigma and Discrimination
"HIV/AIDS-related stigma has been found to play a significant role in whether infected persons access or maintain primary medical care. One recent study examined the level and impact of HIV-related stigma in a culturally diverse sample of persons attending an urban HIV clinic. Using a combination of quantitative and qualitative methods, the researchers found that 'stigma emerged as an insidious deterrent to integrating HIV primary care (e.g. medications, clinic appointments) into daily life.' (Engaging PLWH/As in Care, p. 56)

Providers and consumers consider stigma and discrimination as on-going crosscutting issues in Maryland. According to the SCSN discussions, needs assessment results, and open forum meetings, consumers and providers stress that HIV stigma is a barrier to obtaining services for HIV care, mental health, oral health, affordable housing, and access to medication. Stigma and discrimination are also consistent concerns of the emerging and known special populations. The specific populations include persons with limited-English proficiency, immigrants, residents in rural areas, GLBT persons, incarcerated persons, homeless persons, substance abusers, and youth. HIV stigma prevents disclosure to family members and obtaining services from healthcare providers.

Dental care
Consistent with the findings from the 2001 and 2006 SCSNs, participants agreed in the 2008 RAC meetings that there was a great need for more extensive oral health services. Dental care is a high priority for many participants. As persons with HIV live longer, it is important that they have access to quality oral health care. Persons with missing teeth, periodontal disease, or soft tissue lesions may not be able to take in necessary nutrition, and can compromise their health. IDU's are particularly vulnerable to oral diseases due to the effects of substance abuse.

609 respondents in the Baltimore EMA Consumer Survey of 2007 responded yes when asked if they felt they needed oral health care. However, almost half (44.2%) of those in need had not received the service in the year before the survey. Of these respondents, 25% stated that they did not know how to acquire oral health care, while another 15 % said they could not afford the co-payment.

Case Management
RAC participants in all regions stressed the on-going problem of unmanageably high case management caseloads, "multiple roles" for case managers and a related high turnover of case managers. This was also cited as a serious problem in the 2006 SCSN. Obviously, the high

turnover rates create difficulties and time constraints for both the agencies and the clients. For clients, the need to tell their story over and over again to new case managers can act as a barrier to seeking care. The 2007 Baltimore Consumer Survey reported that almost all of the respondents indicated a need for case management, and that 11.7**%** stated that they needed case management but were not receiving it.

Many SCSN participants stated that there is inconsistency among case managers. Providers and clients alike are advocating a statewide training certification program, mentorship, networking, sensitivity and cultural competency trainings, and venues for sharing resources, new information, and etc. Others also proposed a centralized case management access system.

Housing Assistance

Stable housing is fundamental to success in the lives of persons with HIV/AIDS. This is particularly true because many struggle with co-morbid conditions that make the tasks of daily living even more challenging. Without a home, stress levels increase, further compromising already fragile immune systems. Individuals are exposed to chaotic housing shelters or the uncertainty of life on the streets. Essential nutritional needs are easily neglected or forgotten. While coordination between health and social services is improving, some PLWHA have reported having to choose between attending medical appointments or standing in line to assure a place in a housing shelter for the night. Complex treatment regimens become more difficult to monitor and are frequently derailed when faced with unstable living situations. Appointments with health care and human service providers are more likely to be missed or not scheduled at all. Outreach workers are less likely to be able to find their clients in order to offer ongoing support and treatment. Ryan White-funded housing providers and HOPWA (Housing Opportunities for Persons with AIDS)-funded providers share two goals: to increase permanent, affordable housing resources for individuals and families with HIV/AIDS, and to promote integration of supportive service options for people with HIV/AIDS.

SCSN participants ranked transitional housing/shelter, long-term rental assistance, and other housing needs, as the three most inaccessible housing-related services. Furthermore, "Housing" was ranked the greatest need, above all other service categories. It is reported that neither HOPWA nor Ryan White funding for housing-related services is sufficient to meet the needs. 303 respondents to the Baltimore EMA Consumer Survey from 2007 expressed a need for housing services. Of these, more that half said they had not received it. Among the respondents who had received temporary housing assistance within the past 12 months, about 17% received rent money to prevent eviction, and almost 80% were helped to enter transitional housing. The most commonly cited barrier to receiving this service was not knowing how to get it, cited by around 40% of the EMA respondents who needed this services.

There is a lack of affordable decent housing for low-income individuals and families throughout the state of Maryland. In addition, there is a deficiency of housing assistance services. Regardless of HIV status, clients experience long housing wait lists and shortages in beds in existing transitional shelters. The housing laws now require credit checks for placement and landlords often rely upon credit scores to determine placement and eligibility. Furthermore, security deposits have drastically increased beyond that of the target populations' financial capability.

SCSN Participants suggested integrating HIV support and housing services in housing facilities, including: life skills, medication management, budget management and trained staff to administer a behavioral health to address issues of "arrested development" and coping deficits that are common in the targeted populations. There is also a need for accurate assessments of a client's readiness for housing. This strategy would build a more comprehensive approach to existing service delivery systems.

Mental Health

An estimated 26.3 % of the general population in Maryland has a diagnosis of either anxiety disorder or depressive disorder, with the highest prevalence in Baltimore City. SCSN participants felt that all persons with HIV could benefit from some form of mental health services. Furthermore, 58% of participants felt that mental health services were difficult for clients to access. Participants ranked mental health as the sixth greatest need for PLWHA, and one of the three greatest barriers to obtaining services. There are major cultural and stigma-related barriers to using mental health services. One attendee stated: " A solid mental health foundation is necessary for all other services to work: for HIV medication adherence, for substance abstinence, and for service utilization." Those from the rural regions particularly stressed the lack of availability of mental health treatment and counseling services.

Well over half the respondents (about 59%) of the Baltimore EMA 2007 Consumer Survey felt they needed mental health services, up from 47.5% in 2004. Over one fifth of these (23.2% EMA-wide, 23.5% in Baltimore City, and 21.5% in the counties) indicated an unmet demand, an overall increase from 2004 levels, When those expressing unmet demand were asked why they had not received this service, 23% felt they had not needed it at the time but did need it now, while 12% said they were either unaware of or did not know how to access mental health services.

There is also a growing need for mental health services for special populations, including the pediatric population and limited-English proficiency consumers. Services also need to be made available for family members of HIV-infected persons. With the increased number of people living with HIV who are in need of mental health services, there is a growing need for increased days, hours, clinic locations and services.

Substance Abuse and Addictions Services

Substance abuse continues to be a major issue for PLWHA in Maryland. The Baltimore EMA Consumer Survey showed that, compared to the 2004 survey results, the proportion of respondents in need of substance abuse treatment in Baltimore City increased significantly, from 34.0% in 2004 to 42.6% in 2007, as did the city's unmet service demand, which rose from 14.4% to 21.4%. As the Baltimore EMA Consumer Survey states, "The sizable increases in demand and, in the city, unmet demand for this service – combined with the fact that IDU is a leading transmission mode in the EMA – suggests that substance abusers must remain a population of particular focus in future planning."

An integrated approach to providing substance abuse and addictions services for people living with HIV/AIDS was re-iterated this year as previously. The increasing numbers of clients with

substance abuse problems requires that case managers and other providers be educated about substance abuse, co-morbidity, cultural differences and other issues that may impact treatment outcomes. Providers stressed a need for an extensive list of drug treatment resources to be made available to both providers and clients. As in the earlier SCSN, the need for culturally competence substance abuse services was cited multiple times in the RAC sessions.

The great need for more treatment slots in all modalities in accessible locations, especially inpatient and outpatient clinics outside of Baltimore City, was noted. Participants in the rural regions specified their challenges in the SCSN meeting: in the Eastern region, participants stated that the "trend is an on-going 'no-progress', with an increase in drug use among youth and the older population; in the rural Western region, participants noted increased heroin use in some counties and a lack of treatment facilities. Other counties stated that addiction counselors are not adequately trained in HIV and there is a lack of needle exchange programs.

Prevention and Education

Despite successes in providing education, SCSN participants reported a continued need for basic HIV and AIDS education, as well as updates on new information for both clients and providers. Participants also indicated that there was a continued need to incorporate prevention education into HIV primary care. Participants mentioned several times the lack of knowledge of services and resources which are available; several suggested a need for a jurisdiction-based resource directory and improved "social marketing" of services which are available. Participants report that there is a lack of prevention resources and information on how to use these resources. Providers find that there is limited time and space to provide prevention services and note that increasing the length of an already long appointment can be taxing on the patient.

Transportation

In the 2006-2008 SCSN, transportation was identified as the third greatest need for PLWHA, and the overall greatest problem that clients face while trying to access care. The client-led priority setting process also reflected the significance of this need, as clients in each region voted transportation as one of the top five priorities. Transportation continues to be a major problem, particularly in the rural Maryland regions where there are longer distances to services and extremely limited public transportation. Transportation was cited by participants in all five of the RAC regions. The loss of time seeking out services is a significant barrier for many clients, which contributes to lack of compliance. The need for more mobile vans was stated by participants in several regions.

70.7% of the participants of the 2007 Baltimore EMA Consumer Survey reported the need for medical transportation. Among those with unmet demand, not knowing how to access medical transportation services was cited as a barrier by about half. The survey also asked what forms of transportation respondents had used through this service in the past year. Public transportation was the most common form, utilized by 79.0% of EMA-wide respondents. Another 35.5 % had used cabs, and 17.6% had ridden in medical vans. Volunteer drivers and HIV transportation services were least utilized (5.5% and 7.2% respectively).

II. Where We Need to Go: Our Vision of an Ideal System

Continuum of care for high quality core services

The mission of the AIDS Administration is to reduce the transmission of HIV and help Marylanders with HIV/AIDS live longer and healthier lives through the development and implementation of comprehensive, compassionate and quality services for both prevention and care. The three components of the service-delivery system are: comprehensive, meeting the range of needs presented by a person living with HIV so that treatment can be optimalized; compassionate, understanding of the emotional, physical and social impact HIV can have on those who are infected and affected; and quality, respecting that everyone deserves excellent care and treatment, regardless of their ability to pay for the service. The continuum of HIV care in Maryland is a collaborative effort between federally-funded, state-funded, and privately funded services and agencies. The following vision and values guide the ongoing development and implementation of the continuum of care for Marylanders living with HIV/AIDS.

Vision for system changes

The vision of the AIDS Administration is a Maryland with no new HIV infections. Our vision for those already living with HIV is based upon needs assessment data, epidemiological analyses of HIV/AIDS in Maryland, input from the community and national standards. The following vision guides the Maryland AIDS Administration HIV Services Programs:

- Have a collaborative system of HIV care across all Parts of Ryan White and with other service providers that ensures access to the full range of services needed by Marylanders with HIV/AIDS to live longer and healthier lives.

- All HIV-positive individuals learn their HIV status early and engage and stay in health care.

- All people living with HIV/AIDS live longer, healthier lives regardless of race, ethnicity, gender or sexual orientation.

Values for system changes

The following values guide the development and implementation of service delivery program models to achieve the goals described above:

- All HIV treatment and prevention programs and policies must be based on science and have as their foundation the latest scientific knowledge about HIV epidemiology, transmission and clinical care.

- The HIV health care continuum must be accessible to individuals and families regardless of their ability to pay.

- Methods for routine monitoring and assessment of the outcome of HIV care and supportive services must be in place for all HIV service providers.

- Policy and program design must reflect input from a broad range of people affected by HIV/AIDS, including persons living with HIV and providers engaged in direct care. Communities of color must be central to this collaboration, given the disproportionate impact of HIV on persons of color in Maryland.

- All HIV care and supportive services should receive HIV care in a culturally competent manner.

III. How We Will Get There: Our Goals for System Improvements

In order to meet our program's vision, the following six long-term goals guide the Maryland AIDS Administration HIV Services Programs:

1. Coordinate a collaborative system of HIV care across all Ryan White Parts and with other service providers.

2. Ensure people who are newly diagnosed HIV-positive and those not in HIV care enter HIV health care by collaborating with Counseling, Testing and Referral (CTR) programs and facilitating connections to care and support services.

3. Improve health outcomes by ensuring access to comprehensive, high quality, culturally competent health care for all persons living with HIV/AIDS, emphasizing the importance of retention in care, treatment adherence support and prevention with HIV-positive individuals.

4. Ensure timely and on-going access to life-saving medications for all uninsured and underinsured persons living with HIV/AIDS in Maryland.

5. Improve access to mental health services and substance/alcohol abuse counseling and treatment for persons living with HIV/AIDS and co-morbidities.

6. Provide appropriate case management and access to essential supportive services that enable persons living with HIV/AIDS to seek treatment, remain in care and adhere to medication regimens. Such services include but are not limited to: non-medical case management, medical nutritional counseling, housing assistance, transportation, and emergency financial assistance.

The following chart outlines the specific objectives that will enable the AIDS Administration and its partners to work towards these goals to meet our vision.

Goal	Objective	Responsible Parties	Timeframe
Coordinate a collaborative system of HIV care across all Ryan White Parts and with other service providers.	Continue active participation in Baltimore's Part A Planning Council, attending monthly Council meetings and providing monthly updates of Part B and Part D to the Council.	Deputy Chief, Center for HIV Care Services (CHCS)	Current and ongoing
	Join and actively participate in Washington, D.C.'s Part A Planning Council	Chief, CHCS	By April 2009 and ongoing
	Convene periodic Ryan White-Funded-All-Parts meeting	Chief and Deputy Chiefs, CHCS	By June 2010 and ongoing
Ensure people who are newly diagnosed HIV-positive and those not in HIV care enter HIV health care by collaborating with Counseling, Testing and Referral (CTR) programs and facilitating connections to care and support services.	Improve coordination with CTR by discussing referral systems and monitoring linkages to HIV care reports by CTR	Deputy Chief and Health Services Administrators	By July 2009 and ongoing
	Continue utilization of Part B Minority AIDS Initiative (MAI) funds for outreach and education to HIV positive minorities to engage or re-engage them in the Maryland AIDS Drug Assistance Program (MADAP)	Deputy Chief, CHCS	July 2009 July 2010 July 2011
	Continue providing technical assistance to the Part B MAI grantees to improve program performance	Health Services Administrators	Quarterly
Improve health outcomes by ensuring access to comprehensive, high quality, culturally competent health care for all persons living with HIV/AIDS, emphasizing the	Set statewide quality indicators for clinical services and monitor through Continuous Quality Improvement Steering Committee	Deputy Chief and Health Services Administrators	December 2009

Goal	Objective	Responsible Parties	Timeframe
importance of retention in care, treatment adherence support and prevention with HIV-positive individuals.	Improve Client Level Data collection and reporting process	Deputy Chief and Health Services Administrators	December 2009
	Improve site visit process	Deputy Chief and Health Services Administrators	July 2010
	Provide increased training and technical assistance to funded vendors	Health Services Administrators	Ongoing
Ensure timely and on-going access to life-saving medications for all uninsured and underinsured persons living with HIV/AIDS in Maryland.	Ensure MADAP Advisory Board membership is representative of Maryland's epidemic	AIDS Administration Director	Annually
	Continue MADAP formulary review to ensure optimal coverage of HIV and related medications	MADAP Advisory Board	By July 2009 and annually
	Implement new MADAP data system to better collect, monitor and use data	Deputy Chief, Center for HIV Care Services	December 2009
	Conduct MADAP client satisfaction survey	Health Service Evaluators	2010
Improve access to mental health services and substance/alcohol abuse counseling and treatment for persons living with HIV/AIDS and co-morbidities.	Build partnerships with Alcohol and Drug Abuse Administration and the Mental Health Administration at DHMH to better address needs of the HIV community	AIDS Administration Director, Chiefs, CHCS and Center for Prevention	By December 2009 and ongoing
	Convene regional roundtable discussions to better coordinate mental health and substance abuse system of care across providers/funding streams	Deputy Chief, Center for HIV Care Services	By December 2010
Provide appropriate case management and access to essential supportive services that enable persons living with HIV/AIDS to seek treatment, remain in care and adhere to medication regimens.	Continue Part B funding prioritization process through Regional Advisory Committee meetings	Health Services Administrators	Annually in October
	Convene workgroup to assess current funding formula	Deputy Chief, Center for HIV Care Services	December 2010

The short-term (annual) goals for achievement of the vision of the Health Services program are the Part B Implementation Plan developed each year and submitted to HRSA. This plan is updated on an annual basis. The Part B Implementation Plan for grant year 2009 (April 1, 2009 through March 30, 2010) is included as Appendix D.

IV. How We Will Monitor Our Progress: Our Process for Evaluation

The AIDS Administration has established formal systems to evaluate progress in meeting its goals and objectives. This section will briefly describe the systems and mechanisms that are in place to monitor progress towards meeting the goals of this Comprehensive Plan.

- The Leadership Team of the AIDS Administration regularly monitors progress on the work plan of its strategic plan, which includes a number of the goals included in the chart above. Work teams are set up to address both the collaboration of the oversight and provision of prevention and care services.

- The Center for HIV Care Services within the AIDS Administration is responsible for oversight of the HIV care funded through Ryan White Part B and Part D. The Continuous Quality Improvement Steering Committee of the Center review data from the Maryland AIDS Drug Assistance Program and the funded HIV Care Services to ensure the funds are being effectively used to meet the needs of people living with HIV/AIDS in Maryland.

- The MD AIDS Administration has designated staff for on-going monitoring and evaluation of HIV services programs. Health Services evaluators examine performance and outcome goals and data collected towards measuring attainment of program objectives. The Health Services evaluators coordinate the development and implementation of the client satisfaction surveys, medical record reviews, client focus groups and the SCSN needs assessment process. Quarterly reports are required for Part B-funded agencies and include a programmatic narrative, performance measures per service category and expenditure documents. The narrative section provides a summary of how the program functions, what services are provided and indicates any barriers to providing services and/or program successes. It also presents the program's progress, efforts at increasing adherence to treatment services and services targeting women and children.

- Since January 2004, all Part B and state-funded HIV service providers have been required to submit electronic, unduplicated client level data on a quarterly basis. The Ryan White services data are analyzed for service utilization patterns within geographical areas and by demographic trends. These data are also used to assess client utilization of core services and performance measures.

- There are two client satisfaction surveys that are administered that provide critical feedback on the success of the Part B funded programs in meeting the needs of clients with HIV. A Client Satisfaction Survey for Part A, B and D-funded services is administered annually. Reports are stratified by region and agency. Agency reports are filed in each individual

provider's record and staff review results to ascertain if any corrective action is needed. A MADAP Client Satisfaction Survey is administered bi-annually and provides feedback on access, process and customer service issues related to the pharmacy and insurance premium assistance programs.

- The Ryan White Part B 2009-2011 Comprehensive Plan will be presented at each of the Regional Advisory Committees across the state to inform the consumers, providers and community members of the specific goals and objectives the AIDS Administration has adopted. AIDS Administration will also provide annual updates to the RAC members on progress towards meeting the goals established in this plan. The accountability and opportunity for feedback from consumers, providers and community members is an important component of the evaluation of this plan.

Appendices

APPENDIX A: GLOSSARY OF TERMS AND ABBREVIATIONS

AAMSM	African-American Men Who Have Sex With Men
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
CDC	Centers for Disease Control and Prevention
HetSexPR	Heterosexual contact with a partner who has or is at risk for HIV
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons Living with AIDS
HRSA	Health Resources Services Administration
IDU	Injection Drug User
MCO	Managed Care Organization
MSM	Men Who Have Sex With Men
Part A	HRSA funding to eligible metropolitan areas for HIV medical and support services
Part B	HRSA funding to states for HIV medical and support services
Part C	HRSA funding directly to clinical providers of HIV early intervention medical services
Part D	HRSA funding for women, infants, children and youth Infected and affected by HIV/AIDS
Planning Council	A mandated council, appointed by the Mayor, of local providers and community members that decides how Ryan White Part A funds will be allocated and Part A programs implemented
PLWHA	Person living with HIV/AIDS
RAC	Regional HIV services advisory groups consisting of HIV providers and HIV-infected and affected community members

Ryan White Act	The Ryan White HIV/AIDS Treatment Modernization Act of 2006 is the reauthorization of a federal law enacted in 1990 that addresses the unmet health needs of persons living with HIV disease by funding primary health care and support services.
SCSN	Statewide Coordinated Statement of Need
STD	Sexually Transmitted Disease
UI	The Unique Identifier is a fourteen-digit number consisting of the last four digits of the Social Security number, the date of birth (mm,dd,yyyy), and codes for race/ethnicity and gender

APPENDIX B: HRSA DEFINITIONS OF SERVICE CATEGORIES

Services Funded by the Maryland Ryan White Part B

CORE SERVICES:

Outpatient/ Ambulatory Health Services: Outpatient/Ambulatory medical care (health services) is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in a outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventative care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretrovirals therapies. NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under Outpatient/ Ambulatory medical care.

Oral Health Care: Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists, and auxiliaries, and other trained primary care providers.

Mental Health Services: Mental health services are psychological and psychiatric treatment and counseling services offered to individuals with diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Medical Nutrition Therapy: Medical nutrition therapy is provided by a licensed dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Medical Case Management (including Treatment Adherence): Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a

comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client- specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Substance Abuse Services – Outpatient: Substance abuse services outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and /or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

SUPPORT SERVICES:

Case Management (Non-Medical): Case management (non-medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Child Care Services: Child care services are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training. NOTE: This does not include child care while a client is at work.

Emergency Financial Assistance: Emergency financial assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available. NOTE: Part A and Part B programs must be allocated, tracked, and report these funds under specific services categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formally Policy No. 97-02).

Food Bank/ Home Delivered Meals: Food bank/ home delivered meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and housing cleaning supplies should be included in this item. Includes vouchers to purchase food.

Housing Services: Housing services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or support services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

Medical Transportation Services: Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Outreach Services: Outreach services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiological data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Psychosocial Support Services: Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

APPENDIX C: DIRECTORY OF PART B-FUNDED PROVIDERS, 2009

Organized by Service Category

CORE SERVICES

1. Outpatient/Ambulatory Medical Care

Chase Brexton Health Services	1001 Cathedral Street Baltimore, MD 21202	410-545-4481
Healthcare for the Homeless	111 Park Avenue Baltimore, MD 21201	410-837-5533
Johns Hopkins University-Moore Clinic	1830 E. Monument Street Baltimore, MD 21287	410-614-3430
Park West Medical Center	4120 Patterson Avenue Baltimore, MD 21215	410-764-2266
People's Community Health Center	2204 Maryland Avenue Baltimore, MD 21218	410-467-6040
University of Maryland- Evelyn Jordan Center	22 S. Greene Street Baltimore, MD 21201	410-328-5759
University of Maryland- Maryland General Hospital	22 S. Greene Street Baltimore, MD 21201	410-328-5759
Baltimore County Health Department	6401 York Road Baltimore, MD 21212	410-377-9687
Frederick County Health Department	350 Montevue Lane Frederick, MD 21702	301-631-3347
Howard County Health Department	8492 Baltimore National Pike Ellicott City, MD 21403	410-313-2333
Montgomery County Department of Health and Human Services	2000 Dennis Avenue Silver Spring, MD 20902	240-777-1744
Prince George's County Health Department	3003 Hospital Drive Cheverly, MD 20785	301-583-3722
Wicomico County Health Department	108 East Main Street Salisbury, MD 21801	410-749-1244

2. Oral Health Care

Chase Brexton Health Services	1001 Cathedral Street Baltimore, MD 21202	410-545-4481
Independent Living Foundation	2116 Pratt Street Baltimore, MD 21223	410-233-3323
Johns Hopkins University, Pediatrics	200 North Wolfe Street Baltimore, MD 21287	410-614-9561
University of Maryland at Baltimore- School of Dentistry	666 West Baltimore Street Baltimore, MD 21201	410-706-7625
Charles County Health Department	P.O. Box 1050 White Plains, MD 20695	301-609-6811
Frederick County Health Department	350 Montevue Lane Frederick, MD 21702	301-631-3347

Montgomery County Department of Health and Human Services	2000 Dennis Avenue Silver Spring, MD 20902	240-777-1744
Somerset County Health Department	7920 Crisfield Highway Westover, MD 21871	410-651-6500
Washington County Health Department	1302 Pennsylvania Avenue Hagerstown, MD 21740	301-766-7267
Worcester County Health Department	6040 Public Landing Road Snow Hill, MD 21863	410-632-1100

3. Mental Health Services

Chase Brexton Health Services	1001 Cathedral Street Baltimore, MD 21202	410-545-4481
Johns Hopkins University, Psychiatry	600 North Wolfe Street Baltimore, MD 21287	410-955-6328
University of Maryland, Psychiatry	685 West Baltimore Street Baltimore, MD 21201	
Frederick County Health Department	350 Montevue Lane Frederick, MD 21702	301-631-3347
Montgomery County Department of Health and Human Services	2000 Dennis Avenue Silver Spring, MD 20902	240-777-1744
Prince George's County Health Department	3003 Hospital Drive Cheverly, MD 20785	301-583-3722

4. Medical Nutrition Therapy

Anne Arundel County Health Department	2666 Riva Road, Ste. 310 Annapolis, MD 21401	410-222-7109
Montgomery County Department of Health and Human Services	2000 Dennis Avenue Silver Spring, MD 20902	240-777-1744
Prince George's County Health Department	3003 Hospital Drive Cheverly, MD 20785	301-583-3722

5. Medical Case Management

Baltimore City Health Department-STD Clinic	1515 West North Avenue Baltimore, MD 21217	
Chase Brexton Health Services	1001 Cathedral Street Baltimore, MD 21202	410-545-4481
Family Health Centers of Baltimore	315 North Calvert Street Baltimore, MD 20212	410-500-5600
University of Maryland, Psychiatry	685 West Baltimore Street Baltimore, MD 21201	
Allegany County Health Department	Box 1745 Willowbrook Road Cumberland, MD 21501	301-777-5693
Anne Arundel County Health Department	2666 Riva Road, Ste. 310 Annapolis, MD 21401	410-222-7109
Baltimore County Health Department	6401 York Road Baltimore, MD 21212	410-377-9687

Caroline County Health Department	403 South 7th Street Denton, MD 21629	410-479-2860
Carroll County Health Department	290 South Center Street Westminster, MD 21158	410-876-4926
Cecil County Health Department	401 Bow Street Elkton, MD 21921	410-996-5100
Charles County Health Department	P.O. Box 1050 White Plains, MD 20695	301-609-6811
Dorchester County Health Department	3 Cedar Street Cambridge, MD 21613	410-228-3223
Frederick County Health Department	350 Montevue Lane Frederick, MD 21702	301-631-3347
Harford County Health Department	1 North Main Street Bel Air, MD 21014	410-638-3060
Kent County Health Department	125 South Lynchburg Street Chestertown, MD 21620	410-778-1350
Montgomery County Department of Health and Human Services	2000 Dennis Avenue Silver Spring, MD 20902	240-777-1744
Prince George's County Health Department	3003 Hospital Drive Cheverly, MD 20785	301-583-3722
Somerset County Health Department	7920 Crisfield Highway Westover, MD 21871	410-651-6500
Talbot County Health Department	100 South Hanson Street Easton, MD 21601	410-819-5600
Washington County Health Department	1302 Pennsylvania Avenue Hagerstown, MD 21740	301-766-7267
Wicomico County Health Department	108 East Main Street Salisbury, MD 21801	410-749-1244
Worcester County Health Department	6040 Public Landing Road Snow Hill, MD 21863	410-632-1100

6. Substance Abuse Treatment (Outpatient)

Chase Brexton Health Services	1001 Cathedral Street Baltimore, MD 21202	410-545-4481
Johns Hopkins University-Moore Clinic	1830 E. Monument Street Baltimore, MD 21287	410-614-3430
University of Maryland, Psychiatry	685 West Baltimore Street Baltimore, MD 21201	

SUPPORT SERVICES

7. Non-Medical Case Management

Baltimore City Health Department- STD Clinic	1515 West North Avenue Baltimore, MD 21217	
Chase Brexton Health Services (transitional case management)	1001 Cathedral Street Baltimore, MD 21202	410-545-4481

Johns Hopkins University – OB/GYN	600 North Wolfe Street Baltimore, MD 21287	410-614-4496
LIGHT Health & Wellness Comprehensive Services	P.O. Box 25535 Baltimore, MD 21217	443-226-4873
Park West Medical Center	4120 Patterson Avenue Baltimore, MD 21215	410-764-2266
Total Health Care (transitional case management)	1501 Saratoga Street Baltimore, MD 21217	410-383-3131
University of Maryland- Evelyn Jordan Center	22 S. Greene Street Baltimore, MD 21201	410-328-5759
Baltimore County Health Department	6401 York Road Baltimore, MD 21212	410-377-9687
Cecil County Health Department	401 Bow Street Elkton, MD 21921	410-996-5100
Dorchester County Health Department	3 Cedar Street Cambridge, MD 21613	410-228-3223
Garrett County Health Department	2008 Maryland Highway Mt. Lake Park, MD 21550	301-334-8111
Kent County Health Department	125 South Lynchburg Street Chestertown, MD 21620	410-778-1350
Queen Anne's County Health Department	206 North Commerce Street Centerville, MD 21617	410-758-0720
Somerset County Health Department	7920 Crisfield Highway Westover, MD 21871	410-651-6500
Wicomico County Health Department	108 East Main Street Salisbury, MD 21801	410-749-1244
Worcester County Health Department	6040 Public Landing Road Snow Hill, MD 21863	410-632-1100

8. Emergency Financial Assistance

Allegany County Health Department	Box 1745 Willowbrook Road Cumberland, MD 21501	301-777-5693
Anne Arundel County Health Department	2666 Riva Road, Ste. 310 Annapolis, MD 21401	410-222-7109
Baltimore County Health Department	6401 York Road Baltimore, MD 21212	410-377-9687
Caroline County Health Department	403 South 7th Street Denton, MD 21629	410-479-2860
Carroll County Health Department	290 South Center Street Westminster, MD 21158	410-876-4926
Cecil County Health Department	401 Bow Street Elkton, MD 21921	410-996-5100
Charles County Health Department	P.O. Box 1050 White Plains, MD 20695	301-609-6811
Garrett County Health Department	2008 Maryland Highway Mt. Lake Park, MD 21550	301-334-8111
Kent County Health Department	125 South Lynchburg Street Chestertown, MD 21620	410-778-1350

Queen Anne's County Health Department	206 North Commerce Street Centerville, MD 21617	410-758-0720
Talbot County Health Department	100 South Hanson Street Easton, MD 21601	410-819-5600
Washington County Health Department	1302 Pennsylvania Avenue Hagerstown, MD 21740	301-766-7267
Worcester County Health Department	6040 Public Landing Road Snow Hill, MD 21863	410-632-1100

9. Psychosocial Support Services

Johns Hopkins University-Moore Clinic	1830 E. Monument Street Baltimore, MD 21287	410-614-3430
Johns Hopkins University, Pediatrics	200 North Wolfe Street Baltimore, MD 21287	410-614-9561
Sisters Together and Reaching (STAR)	1505 Eutaw Place Baltimore, MD 21217	410-383-1903
Total Health Care	1501 Saratoga Street Baltimore, MD 21217	410-383-3131

10. Treatment Adherence

Healthcare for the Homeless	111 Park Avenue Baltimore, MD 21201	410-837-5533
Johns Hopkins University-Moore Clinic	1830 E. Monument Street Baltimore, MD 21287	410-614-3430
Johns Hopkins University, Pediatrics	200 North Wolfe Street Baltimore, MD 21287	410-614-9561
University of Maryland, Institute of Human Virology	725 West Lombard Street Baltimore, MD 21201	410-328-5759
University of Maryland, Pediatrics	737 W. Lombard Street Baltimore, MD 21201	410-706-8931

11. Minority AIDS Initiative Outreach

Baltimore City Health Department- STD Clinic	1515 West North Avenue Baltimore, MD 21217	
Healthcare for the Homeless	111 Park Avenue Baltimore, MD 21201	410-837-5533
Total Health Care	1501 Saratoga Street Baltimore, MD 21217	410-383-3131
University of Maryland, Institute of Human Virology	737 W. Lombard Street Baltimore, MD 21201	410-328-5759

APPENDIX D: RYAN WHITE PART B FFY09 IMPLEMENTATION PLAN

Grantee: State of Maryland	**Fiscal Year 2009**	**Page 1 of 3**
Service Priority Name: Access to Core HIV Care Services		**Total Priority Allocation: $6,690,320**
Service Goal: Ensure access to existing and emerging HIV/AIDS treatments that are accessible and delivered according to established HIV-related treatment guidelines and recommendations		**Reference Current Comprehensive Plan: Objectives 1.1-1.6**

Objectives	**Service Unit Definition**	**Quantity**		**Time Frame**	**Funds**
		# of people to be served	# of service units to be provided		
a. Throughout the funding year continue funding for outpatient and ambulatory medical services to appropriate provider organizations	Office Visits	4,600	7,000	12 months	$2,655,715
b. Throughout the funding year continue funding for oral health care services to appropriate provider organizations.	Office Visits	1,200	2,000	12 months	$554,215
c. Throughout the funding year continue funding for mental health services to appropriate provider organizations.	Individual and Group Sessions	900	2,000	12 months	$488,634
d. Throughout the funding year continue funding for outpatient substance abuse services to appropriate provider organizations.	Office Visits	180	1,200	12 months	$132,686
e. Throughout the funding year continue funding for medical case management (including treatment adherence) services to appropriate provider organizations.	Visits (home and office)	4,600	35,000	12 months	$2,859,070

Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

1a. No-show rate for medical visit appointments. Benchmark: <35% no-shows

1b. No-show rate for dental visits. Benchmark: <45% no-shows.

Service Priority Name: AIDS Drug Assistance Program					**Total Priority Allocation: $22,206,395**
Service Goal: Ensure access to existing and emerging HIV/AIDS and related treatments that are accessible and delivered according to established HIV/AIDS and related treatment guidelines and recommendations					**Reference Current Comprehensive Plan: Objective 2.8**
Objectives	**Service Unit Definition**	**Quantity**		**Time Frame**	**Funds**
		# of people to be served	# of service units to be provided		
a. During the fiscal year continue to provide pharmaceuticals to eligible clients.	Number of prescriptions filled	4,200	125,000	12 months	$22,206,395
Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each: • Monitor difference in percentage between surveillance reports and MADAP enrolled clients. Benchmark <3% difference (above or below) in % • Monitor mean CD4 count and viral load of clients enrolled in MADAP by race, gender and ethnicity. Benchmark: decrease of viral load, increase of CD4					

Service Priority Name: Health Insurance Premium Assistance					**Total Priority Allocation: $5,000,000**
Service Goal: Assist in the payment of third-party health insurance premiums and medication co-pays for eligible people living with HIV/AIDS to support access to care and medications.					**Reference Current Comprehensive Plan: Objective 2.9**
Objectives	**Service Unit Definition**	**Quantity**		**Time Frame**	**Funds**
		# of people to be served	# of service units to be provided		
a. Provide health insurance coverage for eligible clients.	Number of months of coverage purchased	1,100	10,000	12 months	$5,000,000
Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each: • Number of months of insurance coverage purchased. Goal: 10,000 months paid.					

Grantee: State of Maryland	**Fiscal Year 2009**				**Page 3 of 3**
Service Priority Name: Access to Support HIV Care Services				**Total Priority Allocation: $815,259**	
Service Goal: Ensure access to existing and emerging HIV/AIDS treatments by funding supportive services				**Reference Current Comprehensive Plan: Objectives 1.5 and 1.7**	
Objectives	**Service Unit Definition**	**Quantity**		**Time Frame**	**Funds**
		# of people to be served	# of service units to be provided		
a. Throughout the funding year continue funding for non-medical case management services to appropriate provider organizations.	Visits (home and office)	1,500	7,000	12 months	$604,515
b. Throughout the funding year continue funding for psychosocial support services to appropriate provider organizations.	Counseling sessions (individual and group)	250	400	12 months	$32,605

Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

a. Number of non-medical case management visits. Goal: 7,000

b. Number of counseling sessions. Goal: 400

APPENDIX E:

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE

Second Quarter 2008 - Data reported through June 30, 2008

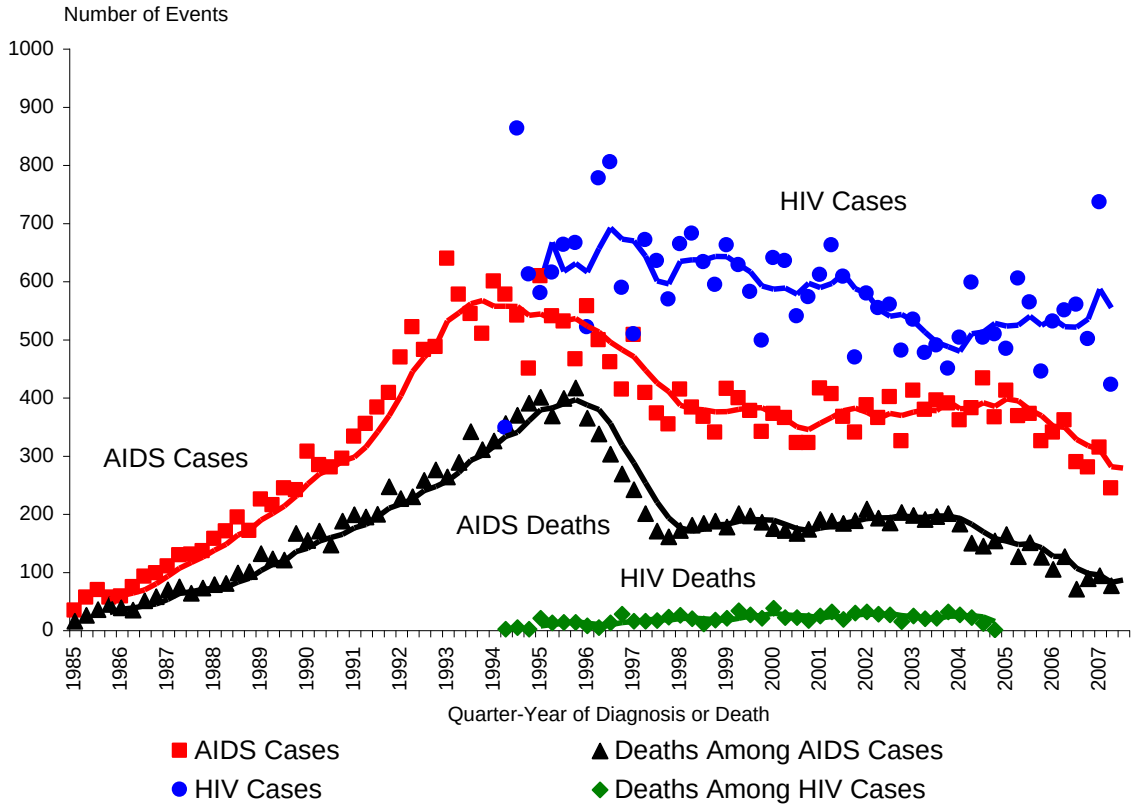
AIDS Administration
Maryland Department of Health and Mental Hygiene
www.dhmh.state.md.us/AIDS/
1-800-358-9001

SPECIAL NOTE ON HIV REPORTING

The Maryland HIV/AIDS Reporting Act of 2007 became law on April 24, 2007. The law expanded HIV/AIDS reporting and required that HIV cases be reported by name. The reporting period presented in this report includes the first first full year of the new reporting, however, most of the tables and figures are as of the end of code-reporting and are unaffected by this change. Section X has been modified to include the changes and future reports will have additional modifications. For additional information on HIV reporting please visit the AIDS Administration web site at the above address.

Section I - HIV and AIDS Case Trends

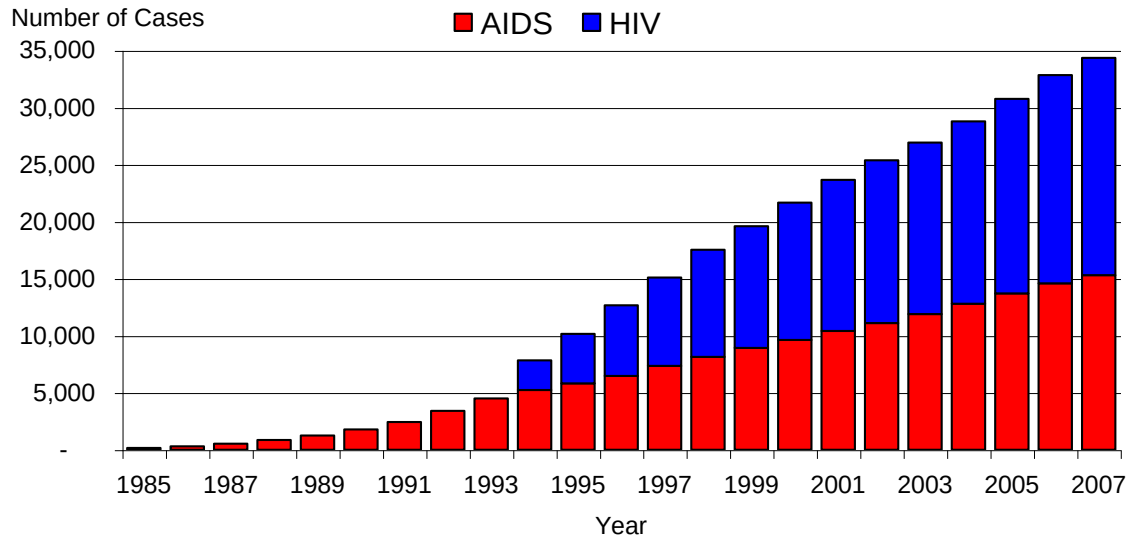
Incident (Newly Diagnosed) HIV and AIDS Cases and Deaths among HIV and AIDS Cases by Quarter-Year through Second Quarter 2007 as Reported through 6/30/08



HIV case reporting began in June of 1994.
Trend lines are weighted moving averages (over 4 quarters).

Section II - HIV and AIDS Case Prevalence Trends

Prevalent (Living) HIV and AIDS Cases on December 31st of Each Year as Reported through 6/30/08



YEAR	HIV	AIDS	Total HIV/AIDS
1985		160	160
1986		301	301
1987		526	526
1988		866	866
1989		1,254	1,254
1990		1,776	1,776
1991		2,431	2,431
1992		3,418	3,418
1993		4,496	4,496
1994	2,594	5,237	7,831
1995	4,348	5,814	10,162
1996	6,194	6,480	12,674
1997	7,735	7,364	15,099
1998	9,380	8,150	17,530
1999	10,676	8,924	19,600
2000	12,039	9,626	21,665
2001	13,238	10,413	23,651
2002	14,262	11,103	25,365
2003	15,026	11,895	26,921
2004	15,974	12,807	28,781
2005	17,049	13,716	30,765
2006	18,246	14,594	32,840
2007	19,042	15,297	34,339

Prevalent cases were alive on December 31st of the given year.
June 30th for HIV in 2007
HIV case reporting began in 1994.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section III - HIV and AIDS Case Geography

Incidence (Newly Diagnosed Cases) during 7/1/06-6/30/07 and Prevalence (Living Cases) on 6/30/07 as Reported through 6/30/08

	Incidence				Prevalence					
	HIV		AIDS		HIV		AIDS		Total HIV/AIDS	
JURISDICTION	No.	%	No.	%	No.	%	No.	%	No.	%
Allegany	4	0.2%	4	0.4%	34	0.2%	35	0.2%	69	0.2%
Anne Arundel	71	3.2%	39	3.5%	501	2.6%	501	3.3%	1002	2.9%
Baltimore City	979	44.2%	475	42.3%	9447	49.6%	6989	46.6%	16436	48.3%
Baltimore	218	9.8%	101	9.0%	1407	7.4%	1114	7.4%	2521	7.4%
Calvert	5	0.2%	7	0.6%	42	0.2%	53	0.4%	95	0.3%
Caroline	5	0.2%	3	0.3%	32	0.2%	24	0.2%	56	0.2%
Carroll	12	0.3%	2	0.2%	98	0.5%	56	0.4%	154	0.5%
Cecil	1	0.4%	4	0.4%	38	0.2%	60	0.4%	98	0.3%
Charles	18	0.4%	20	1.8%	133	0.7%	125	0.8%	258	0.8%
Dorchester	5	0.2%	3	0.3%	60	0.3%	60	0.4%	120	0.4%
Frederick	13	0.6%	4	0.4%	159	0.8%	110	0.7%	269	0.8%
Garrett	0	0.0%	0	0.0%	5	0.0%	4	0.0%	9	0.0%
Harford	50	2.3%	22	1.2%	217	1.1%	191	1.3%	408	1.2%
Howard	31	1.4%	13	1.2%	191	1.0%	172	1.1%	363	1.1%
Kent	0	0.0%	1	0.1%	19	0.1%	17	0.1%	36	0.1%
Montgomery	260	11.7%	135	12.0%	1521	8.0%	1466	9.8%	2987	8.8%
Prince George's	399	18.0%	257	22.9%	2760	14.5%	2732	18.2%	5492	16.1%
Queen Anne's	0	0.0%	0	0.0%	14	0.1%	23	0.2%	37	0.1%
Saint Mary's	1	0.0%	5	0.4%	35	0.2%	48	0.3%	83	0.2%
Somerset	9	0.4%	2	0.2%	54	0.3%	27	0.2%	81	0.2%
Talbot	3	0.1%	1	0.1%	29	0.2%	27	0.2%	56	0.2%
Washington	41	1.9%	8	0.7%	224	1.2%	112	0.7%	336	0.8%
Wicomico	29	1.3%	4	0.4%	203	1.1%	92	0.6%	295	0.9%
Worcester	9	0.4%	4	0.4%	50	0.3%	39	0.3%	89	0.3%
Corrections	52	2.3%	10	0.9%	1769	9.3%	905	6.0%	2674	7.9%
STATE TOTAL	2215	100.0%	1124	100.0%	19042	100.0%	14982	100.0%	34024	100.0%
*STATE RATE**	*41.8*		*21.2*		*359.5*		*282.9*		*642.4*	

HIV case reporting began in 1994.
For code-based HIV cases reported 7/1/06 through 6/30/07, the median time from diagnosis to report was less than one month. For AIDS cases reported 7/1/07 through 6/30/08, the median time from diagnosis to report was three months.
*Rate is number of cases per 100,000 population. Population was based on 2000 Census.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section IV - HIV and AIDS Case Demographics

Incidence (Newly Diagnosed Cases) during 7/1/06-6/30/07 and Prevalence (Living Cases) on 6/30/07 as Reported through 6/30/08

	Incidence				Prevalence					
	HIV		AIDS		HIV		AIDS		Total HIV/AIDS	
GENDER	No.	%	No.	%	No.	%	No.	%	No.	%
Male	1379	62.3%	692	61.6%	11873	62.5%	9937	66.3%	21810	64.2%
Female	833	37.7%	432	38.4%	7109	37.5%	5045	33.7%	12154	35.8%
Missing*	3				60				60	
TOTAL	2215	100.0%	1124	100.0%	19042	100.0%	14982	100.0%	34024	100.0%

	Incidence				Prevalence					
	HIV		AIDS		HIV		AIDS		Total HIV/AIDS	
RACE/ETHNICITY	No.	%	No.	%	No.	%	No.	%	No.	%
White	273	17.0%	139	12.4%	2173	14.0%	2354	15.7%	4527	14.9%
African-American	1205	75.2%	923	82.1%	12604	81.4%	12086	80.7%	24690	81.1%
Hispanic	42	2.6%	51	4.5%	278	1.8%	464	3.1%	742	2.4%
Other	82	5.1%	11	1.0%	424	2.7%	78	0.5%	502	1.6%
Missing*	613				3563				3563	
TOTAL	2215	100.0%	1124	100.0%	19042	100.0%	14982	100.0%	34024	100.0%

	Incidence				Prevalence					
	HIV		AIDS		HIV		AIDS		Total HIV/AIDS	
AGE**	No.	%	No.	%	No.	%	No.	%	No.	%
<5 (Pediatric)	11	0.5%	0	0.0%	37	0.2%	3	0.0%	40	0.1%
5-12 (Pediatric)	5	0.2%	0	0.0%	112	0.6%	29	0.2%	141	0.6%
13-19	66	3.0%	23	2.0%	159	0.8%	132	0.9%	291	0.9%
20-29	464	20.9%	140	12.5%	1815	9.5%	692	4.6%	2507	7.4%
30-39	519	23.4%	296	30.3%	4126	21.7%	2667	23.0%	6793	20.0%
40-49	702	31.7%	411	36.6%	7325	38.5%	6348	42.4%	13673	40.2%
50-59	360	16.3%	200	17.8%	4273	22.4%	4019	26.8%	8292	24.4%
60+	88	4.0%	54	4.8%	1195	6.3%	1092	7.3%	2287	6.7%
TOTAL	2215	100.0%	1124	100.0%	19042	100.0%	14982	100.0%	34024	100.0%

HIV case reporting began in 1994.
*Cases with missing race or gender were excluded from percent distributions.
**For incident cases, age was at time of diagnosis. For prevalent cases, age was as of 6/30/07.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section V - HIV/AIDS Case Expanded Demographics

Total HIV/AIDS Prevalence (Living Cases) on 6/30/07 as Reported through 6/30/08

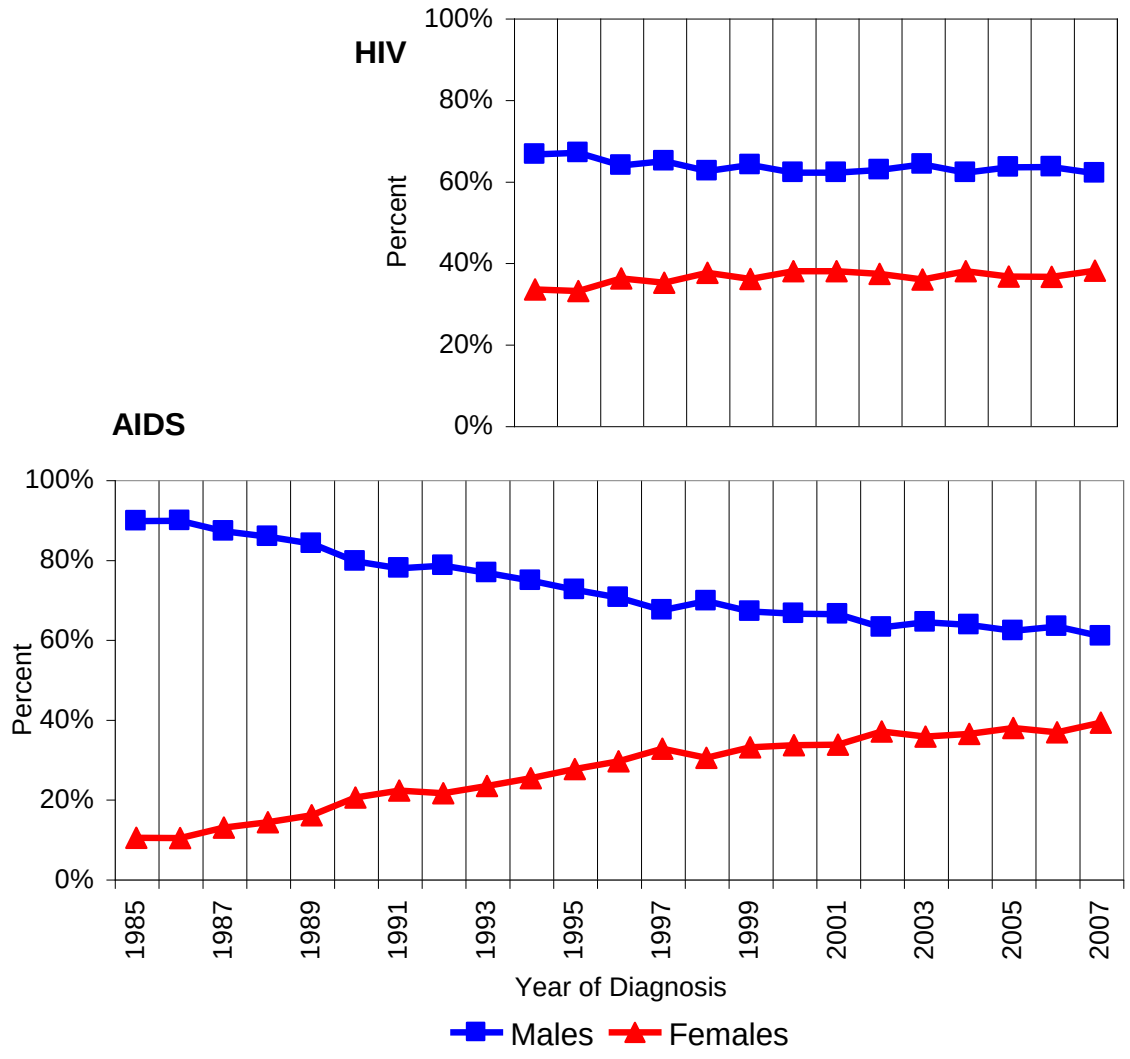
	RACE/ETHNICITY					
GENDER/AGE	White	African-American	Other	Missing Race/ Ethnicity	Total	
	No.	No.	No.	No.	No.	%
Male						
<5 (Pediatric)	1	10	0	12	23	0.1%
5-12 (Pediatric)	10	60	4	16	90	0.4%
13-19	4	112	4	17	137	0.6%
20-29	157	1062	67	178	1464	6.7%
30-39	563	2318	239	407	3527	21.6%
40-49	1438	6494	297	723	8952	41.0%
50-59	841	4472	170	455	5938	27.2%
60+	282	1146	45	206	1679	7.7%
SUBTOTAL	3296	15674	826	2014	21810	100.0%
Female						
<5 (Pediatric)	3	5	0	8	16	0.1%
5-12 (Pediatric)	1	41	1	8	51	0.4%
13-19	12	121	0	21	154	1.4%
20-29	126	664	57	192	1039	8.5%
30-39	386	2210	169	494	3259	26.8%
40-49	458	3656	118	461	4693	38.6%
50-59	181	1863	60	236	2340	19.3%
60+	56	445	11	90	602	5.0%
SUBTOTAL	1223	9005	416	1510	12154	100.0%
Missing Gender	8	11	2	39	60	
TOTAL	4527	24690	1244	3563	34024	

HIV case reporting began in 1994.
Age was as of 6/30/07.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section VI - HIV and AIDS Case Gender Trends

Proportions by Gender of Incident (Newly Diagnosed) Cases during each Calendar Year as Reported through 6/30/08

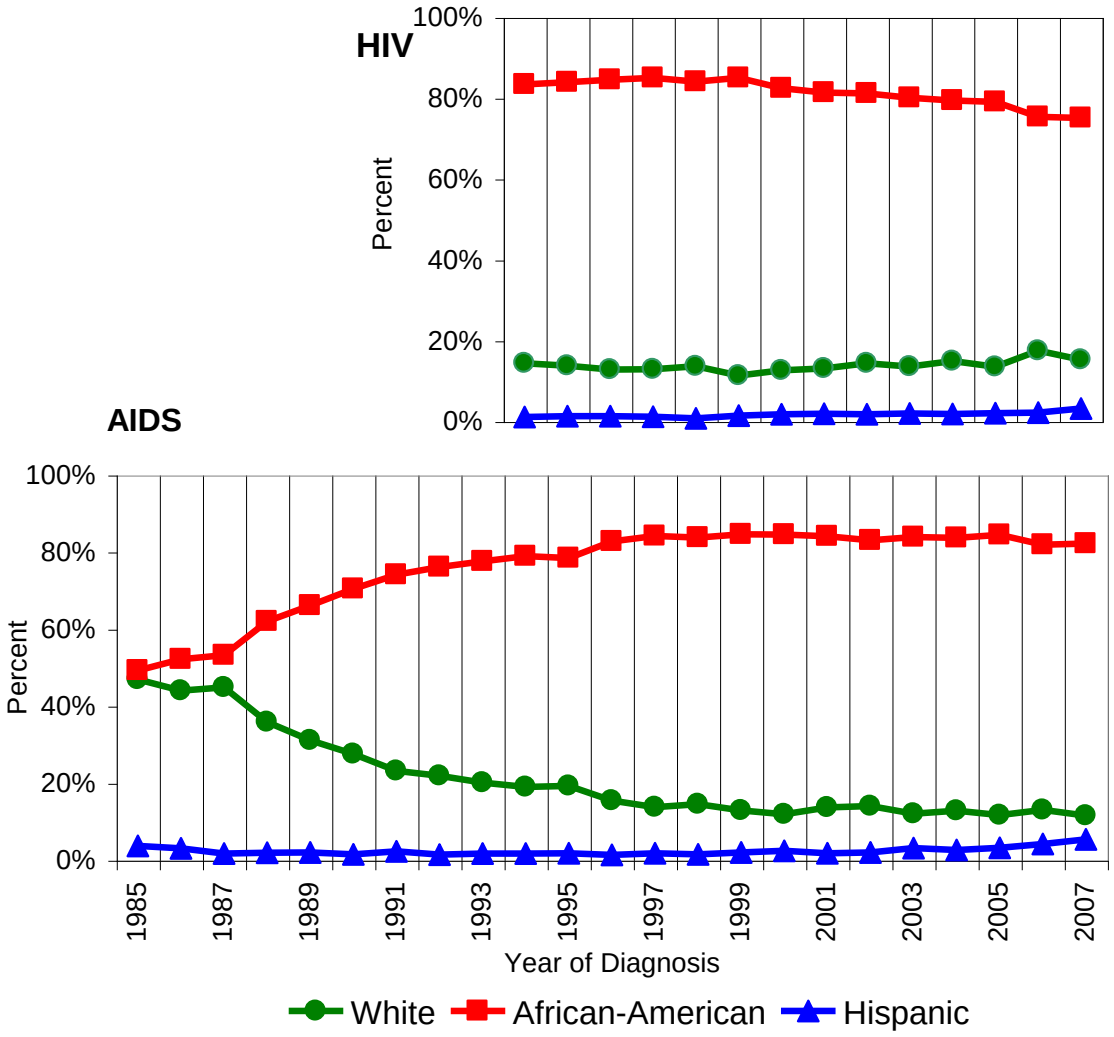


HIV case reporting began in 1994.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section VII - HIV and AIDS Case Race/Ethnicity Trends

Proportions by Race/Ethnicity of Incident (Newly Diagnosed) Cases during each Calendar Year as Reported through 6/30/08

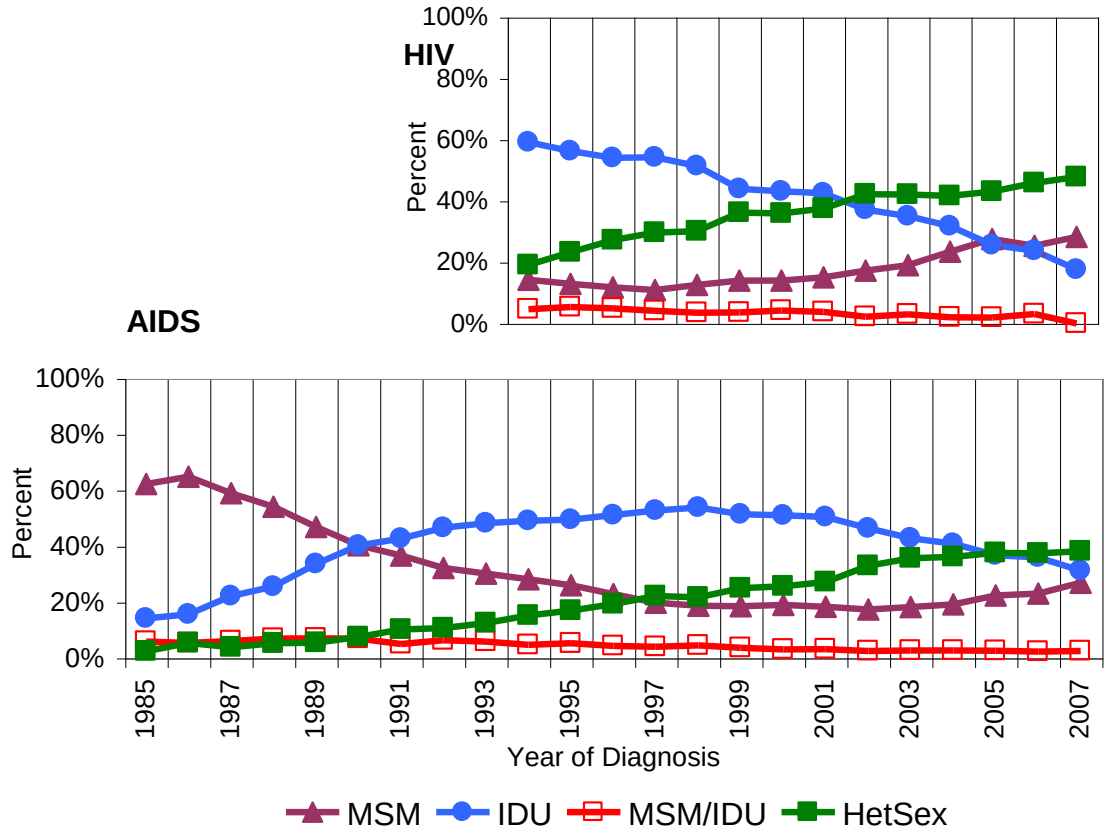


HIV case reporting began in 1994.

MARYLAND HIV/AIDS EPIDEMIOLOGICAL PROFILE - June 30, 2008

Section VIII - HIV and AIDS Case Exposure Category Trends

Proportions by Exposure Category of Incident (Newly Diagnosed) Cases during each Calendar Year as Reported through 6/30/08



Other exposure categories (not shown) that account for small percentages of cases include hemophiliacs, transfusion recipients, pediatric transmissions and occupational exposures.
Percent distributions exclude cases with exposure category under investigation and risk not specified.
Maryland data had exposure on 54% of HIV cases and 92% of AIDS cases.
HIV case reporting began in 1994.

MSM = Men who had sex with men
IDU = Injection drug users
MSM/IDU = Men who had sex with men and were injection drug users
HetSex = Heterosexual contact

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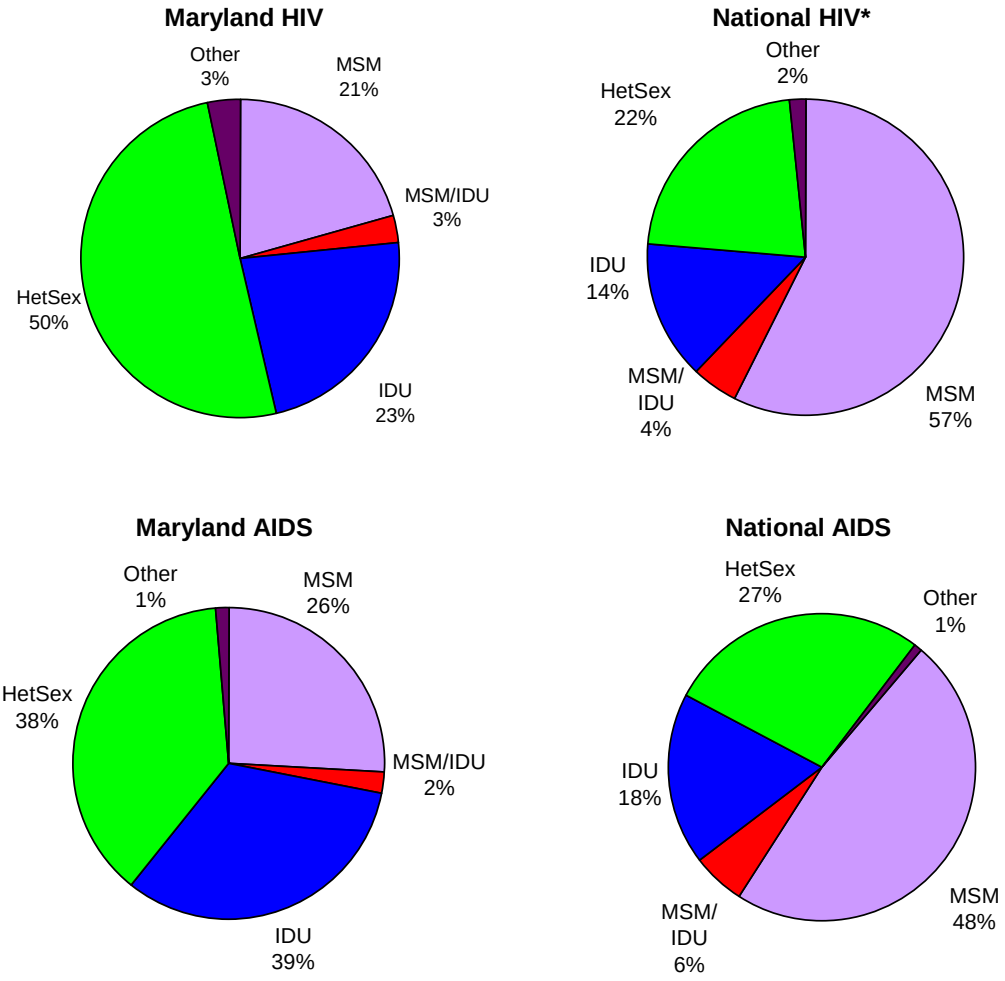
Section IX - Comparisons to National Statistics

HIV and AIDS Cases Reported during 1/1/06-12/31/06

Maryland had the third highest annual AIDS case report rate of any state in 2006 (29.0 cases per 100,000 population) and Baltimore-Towson had the second highest rate of any metropolitan area in 2006 (37.7 cases per 100,000 population). The national rate in 2006 was 12.9 cases per 100,000 population.



* National HIV data included only persons with HIV infection that had not progressed to AIDS. National data was only available from the 45 states and 5 territories with confidential name-based HIV infection reporting as of 12/31/06. Maryland HIV and AIDS data were reported as mutually exclusive categories for comparison to national statistics.

Percent distributions excluded cases with occupational exposure, exposure category under investigation, and risk not specified.

Source for national data: Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report 2006;18:29-38.

MSM = Men who had sex with men
IDU = Injection drug users
MSM/IDU = Men who had sex with men and were injection drug users
HetSex = Heterosexual contact
Other = Hemophiliacs, transfusion recipients, and pediatric transmissions

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Section X - HIV and AIDS Case Reports by Jurisdiction

Events Reported during the Last Year (7/1/07-6/30/08) and Cumulatively through 6/30/08

	HIV Cases					AIDS Cases			AIDS Deaths		
	by Code		by Name								
	Non-AIDS Cumulative		Year	Non-AIDS Cumulative		Year	Cumulative		Year	Cumulative	
JURISDICTION	No.	%	No.	No.	%	No.	No.	%	No.	No.	%
Allegany	39	0.2%	19	29	0.3%	12	71	0.2%	1	33	0.2%
Anne Arundel	505	2.6%	172	278	3.0%	55	1034	3.2%	9	509	3.0%
Baltimore City	9746	49.9%	3000	5380	57.1%	530	16641	51.7%	153	9489	56.7%
Baltimore	1433	7.3%	360	644	6.8%	120	2261	7.0%	15	1106	6.6%
Calvert	45	0.2%	28	30	0.3%	11	98	0.3%	1	44	0.3%
Caroline	32	0.2%	21	31	0.3%	6	60	0.2%	0	34	0.2%
Carroll	99	0.5%	46	59	0.6%	7	105	0.3%	1	47	0.3%
Cecil	39	0.2%	33	37	0.4%	4	112	0.3%	0	52	0.3%
Charles	135	0.7%	74	81	0.9%	17	225	0.7%	3	94	0.6%
Dorchester	64	0.3%	12	35	0.4%	7	129	0.4%	2	66	0.4%
Frederick	164	0.8%	19	29	0.3%	8	207	0.6%	1	93	0.6%
Garrett	5	0.0%	1	1	0.0%	1	8	0.0%	0	4	0.0%
Harford	219	1.1%	54	95	1.0%	24	384	1.2%	1	183	1.1%
Howard	194	1.0%	59	89	0.9%	16	346	1.1%	2	165	1.0%
Kent	17	0.1%	13	16	0.2%	3	34	0.1%	0	14	0.1%
Montgomery	1536	7.9%	281	388	4.1%	146	2721	8.4%	9	1188	7.1%
Prince George's	2790	14.3%	750	1348	14.3%	270	5309	16.5%	17	2424	14.5%
Queen Anne's	16	0.1%	4	10	0.1%	2	55	0.2%	0	30	0.2%
Saint Mary's	36	0.2%	25	32	0.3%	12	92	0.3%	1	39	0.2%
Somerset	55	0.3%	13	18	0.2%	1	60	0.2%	0	33	0.2%
Talbot	29	0.1%	14	32	0.3%	2	83	0.3%	1	55	0.3%
Washington	235	1.2%	97	114	1.2%	20	209	0.6%	0	90	0.5%
Wicomico	209	1.1%	46	58	0.6%	5	249	0.8%	1	155	0.9%
Worcester	52	0.3%	11	16	0.2%	1	94	0.3%	0	54	0.3%
Corrections	1844	9.4%	325	565	6.0%	22	1627	5.1%	11	726	4.3%
TOTAL	19538	100.0%	5477	9415	100.0%	1302	32214	100.0%	229	16727	100.0%

Laboratory reporting of HIV cases by code existed from June 1, 1994 to April 24, 2007.
Provider and laboratory reporting of HIV cases by name has existed since April 24, 2007.

Maryland is re-reporting code HIV cases by name, therefore, the same person may appear as a code HIV case and as a name HIV case.

Year data were for events reported during the prior year, including events that occurred earlier.
HIV cases reported during the prior year may also have been reported as AIDS cases during that time.
Non-AIDS cumulative HIV cases included all HIV cases reported through the end of the period, that had not been reported as AIDS cases by the end of the period.
AIDS deaths included all causes of death.

The median time from diagnosis to report was one month for cumulative non-AIDS HIV code cases, 21 months for cumulative non-AIDS HIV name cases, and four months for cumulative AIDS cases.

APPENDIX F: REGIONAL EPIDEMIOLOGICAL NARRATIVES

The Maryland HIV/AIDS Reporting Act of 2007 became law on April 24, 2007. The law expanded HIV and AIDS reporting, instituted reporting for HIV-exposed newborns, changed Maryland's HIV reporting from a code-based to a name-based system as is done with AIDS cases, increased the restrictions on the use of surveillance data, and increased the penalties for misuse of surveillance data. The state is in the midst of a major effort to transition from code-based to name-based HIV surveillance; hence, the data collected under the new system were not yet available for this report.

This report uses the HIV and AIDS surveillance data available in 2008 that was used during the statewide planning process and for the FY2009 Ryan White funding application. Under this system, AIDS cases and symptomatic HIV cases were reported to the health department using the patient's name by physicians. HIV positive test results and CD4+ T-lymphocyte cell counts less than 200 cells per microliter were reported to the health department using a patient unique identifier number by all laboratories licensed by the State of Maryland. HIV data are available only for those tested since 1994, when HIV surveillance began. HIV and AIDS incident cases are not necessarily mutually exclusive since HIV cases may have progressed to AIDS during the presented time period and therefore count as both a new case of HIV and a new case of AIDS. HIV and AIDS prevalent cases are mutually exclusive categories; therefore, HIV prevalent cases are only those cases that have not developed AIDS. Due to the delay in case reporting, the data are presented with a one year lag, at which point it is estimated that over 90% of cases will have been reported.

Central Region

The number of incident (new) AIDS cases diagnosed within each quarterly period in the Maryland Ryan White Part B Central Region (Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties) increased through 1995 to a high of around 325 cases per quarter, with an artificial rise around 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995, to a high of 276 in the first quarter of 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there was a substantial decline in both the number of new cases of AIDS (to 195 in the third quarter of 2000) and in deaths among AIDS cases (to 138 in the first quarter of 2004). The number of deaths among AIDS cases declined initially at a faster rate than the number of new AIDS cases per year, resulting in an increase in the number of people living with AIDS each year (prevalence). However, the decrease in AIDS deaths stopped in 1998 and the number of deaths per quarter has been stable through 2004 and then began declining again. The number of new HIV cases reported each quarter has been decreasing since surveillance began in 1994 (to 315 in the fourth quarter of 2006).

The total number of living HIV cases (reported since 1994) and AIDS cases has been steadily increasing. There were a total of 20,199 living HIV and AIDS cases in the Maryland Ryan White Part B Central Region as of December 31, 2006, of which 11,448 (57%) were HIV cases and 8,751 (43%) were AIDS cases. Sixty-two percent of all living HIV and AIDS cases in Maryland were residents of the Central Region at time of diagnosis. Of the cases in the Central Region, 78% were residents of Baltimore City and 12% of Baltimore County.

Central Region living HIV and AIDS cases are predominantly African-American (84%), male (63%), and middle-aged; 61% of cases are 30-49 years old. The percentage of female cases has remained steady over time at 37% of new HIV cases. The percentage of African-American cases has declined slightly over time to 79% of new HIV cases. The percentage of cases aged 40-49 at time of diagnosis has also risen to 36% of new HIV cases in 2006.

Forty-five percent of all living HIV and AIDS cases with known transmission risk report injection drug use (IDU), 31% report heterosexual contact (HetSex), and 18% report men who have sex with men (MSM) as mode of exposure. Injection drug use is the predominant mode of exposure reported among men in the Central Region, but IDU and HetSex are equally common among women.

Injection drug use was the most common mode of exposure among new HIV cases, but has been declining steadily, and since 2005, heterosexual contact has been the most common (47% HetSex, 27% IDU in 2006). The proportion of cases among men who have sex with men has also been rising, to 20% in 2006.

Eastern Region

The number of incident (new) AIDS cases diagnosed within each year increased through 1995, with an artificial rise around 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there has been a substantial decline in both the number of new AIDS cases (to 28 in 2002) and in deaths among AIDS cases (to 17 in 1999). The number of deaths among AIDS cases declined at a faster rate than the number of new AIDS cases per year, resulting in a slow increase in the number of people living with AIDS each year (prevalence). Since the number of new HIV cases reported each year is greater than the number of deaths, the total number of living HIV cases (reported since 1994) and living AIDS cases has been steadily increasing.

There were a total of 833 living HIV and AIDS cases in the Maryland Ryan White Part B Eastern Region (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties) as of December 31, 2006. Of these 833 living cases in the Eastern region, 476 (57%) were HIV cases and 356 (43%) were AIDS cases. Of all reported HIV/AIDS cases in Maryland, 3% were residents of the Eastern Region at time of diagnosis. Of the cases reported in the Eastern Region, 33% were residents of Wicomico County and 14% were residents of Dorchester County.

Eastern Region HIV/AIDS cases are predominantly African American (64%), male (64%), and middle-aged - 61% of cases are 30-49 years old. The percentage of female HIV cases has increased slightly over time. The percentage of African-American cases in the Eastern region has increased, and became the largest racial/ethnic group in 1995. The percentage of HIV cases age 40-49 at diagnosis has been increasing and surpassed age group 30-39 to become the largest percent of new HIV cases in 2004.

Heterosexual contact (HetSex) has represented increasing proportions of all new HIV cases in the Eastern Region and is currently the most common mode of HIV transmission. Thirty-one percent of all living HIV/AIDS cases are MSMs, 21% are IDUs, and 44% report heterosexual contact (HetSex).

Southern Region

The number of incident (new) AIDS cases diagnosed within each year increased through 1996. There was an artificial rise in 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there has been a decline in both the number of new cases of AIDS (to 13 in 2001) and in deaths among AIDS cases (to 5 in 2004). The number of deaths among AIDS cases declined at a faster rate than the number of new AIDS cases per year, resulting in a slow increase in the number of people living with AIDS each year (prevalence). The number of new HIV cases each year in the Southern Region has been decreasing by 2% per year (to 26 cases in 2006). Overall, the total number of living HIV cases (reported since 1994) and AIDS cases has been steadily increasing.

There were a total of 414 living HIV and AIDS cases in the Southern Region (Calvert, Charles, and Saint Mary's counties) as of December 31, 2006, of which 204 (49%) were HIV cases and 211 (51%) were AIDS cases. One percent of all living HIV and AIDS cases in Maryland were residents of the Southern Region at time of diagnosis. Of the cases in the Southern Region, 61% were residents of Charles County, 20% of Calvert County and 19% of St. Mary's County.

Southern Region HIV and AIDS living cases are predominantly African American (68%), male (60%), and 30-49 years old (68%). The percentage of newly diagnosed female HIV cases has increased slightly over time. The percentage of African-American HIV cases has generally increased over time, and African Americans have been the predominant racial/ethnic group newly diagnosed with HIV since 1994. Among new HIV cases, the proportion aged 30-39 has been decreasing slightly, while the proportion 20-29 has been increasing slightly.

Heterosexual contact (HetSex) has represented increasing proportions of all new HIV cases and is currently the most common mode of HIV transmission in the Southern Region. The proportion of new HIV cases that are MSM has also been increasing. Fifty percent of all living HIV/AIDS cases in the Southern Region report HetSex as the mode of transmission, 31% are men who have sex with men (MSM), and 15% are injection drug users (IDU).

Suburban Region

The number of incident (new) AIDS cases diagnosed within each quarterly period in the Maryland Ryan White Part B Suburban Region (Montgomery and Prince George's counties) increased through 1995, with an artificial rise around 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there was a substantial decline in both the number of new cases of AIDS (to 67 in the fourth quarter of 1997) and in deaths among AIDS cases (to 29 in the second quarter of 2002). The number of new AIDS cases has been increasing since 1998, while the number of deaths among AIDS cases has continued to decline, resulting in a continued increase in the number of people living with AIDS each year

(prevalence). The number of new HIV cases reported each year has been generally increasing by 4% per year since surveillance began in 1994 (to 139 in the fourth quarter of 2006).

The total number of living HIV cases (reported since 1994) and AIDS cases has been steadily increasing. There were a total of 8,023 living HIV and AIDS cases in the Maryland Ryan White Part B Suburban Region as of December 31, 2006, of which 4,048 (50%) were HIV cases and 3,976 (50%) were AIDS cases. Twenty-four percent of all living HIV and AIDS cases in Maryland were residents of the Suburban Region at time of diagnosis. Of the cases in the Suburban Region, 65% were residents of Prince George's County and 35% of Montgomery County.

Suburban Region living HIV and AIDS cases are predominantly African-American (79%), male (61%), and middle-aged; 64% of cases are 30-49 years old. The percentage of female cases has increased slightly over time to 39% of new HIV cases in 2006. The percentage of African-American cases has been decreasing, to 72% of new HIV cases in 2006. The proportion of cases with race/ethnicity reported as "other", many of whom are recent African immigrants, has been increasing and was 18% in 2006. The age group 30-39 year old has been decreasing, while the age group 40-49 old has been increasing.

In 1994, the Suburban Region had roughly equal proportions of heterosexual contact (HetSex, 30%), injection drug use (IDU, 35%), and men who have sex with men (MSM, 28%) among the new HIV cases. Since then, the region has experienced a substantial increase in the proportion of new HIV cases that report HetSex as their HIV exposure (57% of new cases in 2006) and an equally dramatic decrease in injection drug use (IDU) cases (5% in 2006). After a long, gradual decline, MSM cases have surged during the last two years to 35% in 2006). Among prevalent cases on 12/31/2006, HetSex represented 49%, MSM 31%, and IDU 15%.

Western Region

The number of incident (new) AIDS cases diagnosed each year in the Maryland Ryan White Part B Western Region (Allegany, Frederick, Garrett, and Washington counties) increased through 1995, with an artificial rise around 1993 due to changes in the AIDS case definition. The number of deaths among AIDS cases also increased through 1995. Beginning in 1996 and coincident with the introduction of protease inhibitor therapy, there was a decline in both the number of new cases of AIDS (to 14 in 1997) and in deaths among AIDS cases (to 2 in 1998). The number of deaths among AIDS cases declined at a faster rate than the number of new AIDS cases per year, resulting in a slow increase in the number of people living with AIDS each year (prevalence). Since 1998, there have been no major changes in the number of AIDS cases or deaths in Western Maryland. The number of new HIV cases diagnosed in Western Maryland each year has been increasing since surveillance began in 1994 (to 63 in 2006).

The total number of living HIV cases (reported since 1994) and AIDS cases has been steadily increasing. There were 656 living HIV and AIDS cases in the Maryland Ryan White Part B Western Region as of December 31, 2006, of which 406 (62%) were HIV cases and 250 (38%) were AIDS cases. Two percent of all living HIV and AIDS cases in Maryland were residents of the Western Region at the time of diagnosis. Of the cases in the Western Region, 40% were residents of Frederick County and 49% of Washington County.

Living HIV and AIDS cases in the Western Region of Maryland are predominantly white (61%), male (72%), and middle-aged (65% of cases are 30-49 years old). The percentage of female cases has been increasing slightly over time. The percentage of African-American cases has been increasing over time. Men who have sex with men (MSM) is the most common mode of transmission reported by living HIV and AIDS cases in Western Maryland (41%). Heterosexual exposure (HetSex) has represented an increasing proportion of all new HIV cases and is now the most common exposure category among new HIV cases (40% in 2006).

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